The Canadian Nurse

A Monthly Journal for the Nurses of Canada

Published by the Canadian Nurses Association

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The Injection Treatment of Varicose Veins

By J. H. COUCH, M.B., F.R.C.S. Edin., Department of Surgery, Toronto General Hospital

The treatment of varicose veins has been revolutionised during recent years. Only a short time ago the regular treatment was by operation. A tedious dissection was involved, and long, unsightly scars remained at the various points of incision between the upper thigh and ankle. Nor were the final results satisfactory. Aside from expense and tedium of a convalescense lasting from four to six weeks, the enlarged veins themselves recurred in 15% of cases, and approximately ½ of 1% of all patients subjected to operation died of an embolus to the lung.

Varicose veins may now be completely cured without interfering with the patient's daily routine of work. The operation involves nothing more than a needle prick, no scars are left, about 4% only recur, and the number who die from pulmomary emboli is only 1/70 as great as under the former treatment. In fact, the danger of emboli is probably less in cases treated by injection than if left untreated.

History: The history of the modern method may be briefly sketched. In the latter half of the last century physicians in Germany and France observed that the intravenous administration of strong chemicals in the treatment of syphilis sometimes caused thrombosis of veins. This led them to attempt deliberately to thrombose varicose veins. The results were excellent as far as thrombosis was concerned, but the chemical reactions were so severe that sloughs and ulcers occurred. For this reason the injection treatment fell into disrepute. It has been revived with the discovery of more suitable chemicals and it is now possible to produce an excellent thrombosis of the veins without the unhappy consequences which were previously so common.

The incidence of varicose veins seems to be increasing in civilised communities, although it is difficult to arrive at any accurate estimate of the number of people suffering from this disease. If one may judge from the numbers who seek relief when opportunity is presented, it is safe to say that there are many who have suffered for a long time without complaint. Their disability, while exhausting, is not quite severe enough to justify extensive operation.

Complaints: The reasons which bring the patient to the doctor vary. With some, particularly young people, it is pride. They dislike this disfigurement, of which they are constantly conscious, and which interferes definitely with their happiness and ability to enjoy life. When in public they remain constantly in the background, fearful lest others remark their veins. Fear brings others, who have seen people with enormous varicose veins, and who, with good reason, fear that their own may become worse. The fear that the vein may burst and bleed dangerously is also an ever-present reality. Patients have been brought into hospital so

exsanguinated as to be pulseless and unconscious. Chronic ulcer is the terror of some patients. A large, repulsive and painful sore from which there seems no escape for years is an affliction which has limited the success of more than one. Some patients seek relief because of pain and aching aggravated by standing, while a few complain that their feet and ankles swell.

Circulation: An understanding of the venous circulation in the leg is necessary if the treatment is to be understood. The muscles of the leg are ensheathed in a strong, unyielding covering of deep fascia, within which are large veins, well supported by muscles, capable of enormous work, and rarely subject to varicosities. It is these veins which are damaged in "milk leg," or any form of deep thrombophlebitis. Under normal conditions the work of these deep veins consists of the return of blood from the muscles and bones. On the outside of the deep fascia is another set of veins lying in the fat and superficial fascia under the skin. These veins are not supported by muscle and are prone to become dilated and varicosed when unfavourable conditions arise. Their function is normally to return the blood from the skin and superficial fascia to the deep veins in the groin.

Causes: Varicose veins are not produced by any single cause, but in all cases several factors are at work. Predisposing factors are heredity and debility following illness. Over 50% of patients give a positive family history, while the incidence of varicose veins in the general population is distinctly less than 50%. Microscopic investigation reveals veins which are actually thin walled and weak. If an individual who inherited poor veins be debilitated by illness and then subjected to circumstances which harass the return of blood from the leg, varicosities of the superficial veins may occur. Occupation is frequently a precipitating factor, as is illustrated by the suffering of nurses, teachers, salesgirls, housewives, storekeepers, and policemen. Intra-pelvic pressure, most commonly due to pregnancy, may be a further precipitating cause. This slight interference with the ready return of blood prolonged over a period of nine months may cause varicosities or aggravate an already existing condition.

Once a slight dilatation has occurred, the valve cusps no longer meet in the centre of the vein and blood leaks back past them. Normally, there are no valves in the intra-abdominal or thoracic veins. Therefore, in such cases, the superficial, unsupported veins are forced to bear the weight of a column of blood extending from the foot to the heart, which represents in the erect position a considerable lift against gravity. It has been demonstrated that the pressure in certain parts of varicose veins may reach 170 millimetres of mercury, or 40 millimetres greater than arterial blood pressure. Since these veins are denied the most powerful emptying force, namely, massage by muscle action, it is to be expected that they should sometimes fail. Gravity overcomes the propulsive force, the flow is reversed, the vein below dilates and stretches, and a typical tortuous varicose vein results. As the blood flows slowly down, it perfuses the skin and superficial fascia with useless, stagnant blood low in oxygen and food content, dams back the inflow of fresh blood from the arterial capillaries, and finally finds its way by means of communicating branches through the deep fascia into the capable and tolerant, but not inexhaustible deep veins, by which it is then carried upward toward the heart. At the saphenous opening in the groin some overflows back down into the long saphenous vein, and a vicious circle is established. Thus it becomes evident that veins which have become varicose not only fail to perform any useful function, but they are worse than useless because they compel the deep veins to

do not only their own work and the work of the superficial veins, but even to do some of this work over and over again. It is for this reason that the obliteration of the superficial veins actually improves the circulation in the leg.

Contra-Indications: It might be well here to mention the more important contra-indications to the injection of veins. In some cases of "milk leg" or deep thrombophlebitis, often associated with pregnancy, typhoid fever or following operation, this excellent system of deep veins has been permanently damaged and the superficial veins are compelled to carry most of the blood from the whole leg. While they do this work poorly enough, they still represent almost the only return circulation that the patient has and they must never be injected. In patients with thrombosed deep veins, the superficial veins become large and tortuous from overloading, but their flow is upward in the correct direction. Acute or subsiding phlebitis is a second definite contra-indication to injection, and is evidenced by heat, redness, swelling, pain, and tenderness along the vein. The further irritation in the presence of acute inflammation may result in a widespread extension of the process, which assumes dangerous proportions. An acute inflammatory process anywhere in the body should be cured before veins are treated. Boils or acute sore throats are sometimes accompanied by bacteria circulating in the blood stream, which would find a favourable site for growth in a recently clotted vein. The exact cause of the patient's symptoms must be determined. It is obvious that injection of varicose veins will not relieve the swelling of chronic nephritis or of heart disease, nor will it ease the pain of arthritis or fallen arches; yet all of these are encountered in the clinic.

Technique: The technique of injection treatment is simple in itself, but attention to the details mentioned is necessary if good results are to be obtained and if distressing complications are to be avoided. The patient is seated on a table with the foot resting on a bench below, while the operator sits in front. A small glass syringe, with a long, fine-bore needle (24 gauge, long hypodermic needle) and having a short bevel and a sharp point, is introduced, bevel down, into the vein. When blood is seen in the tip of the syringe the vein is stripped empty above and below by means of the thumb and first finger of the left hand and the contents of the syringe is injected rather quickly. One cubic centimetre of 5% sodium morrhuate is injected in each of two places at each sitting. The two places are usually about four inches apart and cut off a segment of the same vein. Immediately on withdrawing the needle the vein is compressed at the site of puncture by means of a small pledget of cotton held firmly in position with a strip of adhesive for forty-eight hours. The patients are encouraged to continue their ordinary duties. Such injections may be repeated in other affected veins once or twice weekly, and about five sittings are required for the average case.

Rationale: The aim of the treatment is not, as is sometimes thought, to produce a clotting of the blood within the vein. The primary object is to produce a severe chemical damage to the intimal lining of an empty vein in order that a sterile inflammatory reaction may be caused and the two walls of the vein fused together. As a secondary effect it naturally follows that any blood left within the vein must undergo clotting, but the clot is sterile, as against that formed in ordinary thrombophlebitis of infectious origin. The injection of the irritant chemical causes the vein to go into spasm which contracts it to small size, the intimal lining is damaged, the two walls are fused together, and the sterile thrombus which does result is in a contracted, damaged vein, and is therefore small and ad-

heres firmly to the vein wall. These are, perhaps, the main reasons why emboli from veins so treated are so rare. In addition, the fact that the reverse flow of blood tends to jam the clot tighter into the vein rather than to wash it into the general circulation may be of some value in preventing emboli.

Normal Course: As a result of the injection treatment the affected veins normally become small and hard at once, and this reaction may extend in either direction from the point of injection for a distance of about four inches. Sometimes a slight brownish discolouration appears over the hard vein, and occasionally the sterile inflammatory reaction extends out for one inch on either side of the involved vein. This results in a feeling of stiffness and soreness and the production of a tender, hard mass which may cause some discomfort for forty-eight hours, but which need not interfere with the patient's work. Any tenderness or redness should disappear within a day or so, leaving the small, hard, lumpy veins, which are absorbed and disappear of themselves in about six months.

Untoward Effects: Occasionally untoward effects follow such treatment, due either to individual idiosyncrasy or to errors in technique. (1) Cramps in the muscles, usually of the calf, may be encountered. This condition seems to vary with the chemical used for injection. Strong saline solutions are particularly likely to produce them, but they usually disappear in two minutes and the results thereafter continue to be normal. (2) Local pain may occur at the site of injection. This is a severe stinging pain and it indicates that some of the solution has been injected outside the vein wall. The injection should be discontinued immediately. (3) Toxic manifestations may follow the administration of various drugs in individuals who happen to carry a sensitivity to this particular substance. Thus, severe headache, buzzing in the ears, and even uterine contractions have been produced by small doses of quinine, while in others a distressing and widespread, though transient, urticaria occurs. This may be satisfactorily controlled by the hypodermic administration of 10 minims of adrenalin.

Further, such unhappy consequences as the following may occur some time after the injection treatment: (1) Periphlebitis; the normal inflammatory reaction involves the surrounding tissue to an undue degree. Patients so affected suffer from widespread, hard, red, tender swelling following the course of the vein. They should be put to bed and cold saturated magnesium sulphate compresses should be applied until the condition subsides, usually within five or six days. (2) Slough; if the strong irritant chemical solution is injected outside the vein and immediately under the skin it destroys an overlying area of skin, about one inch in diameter. This area sloughs, leaving an indolent ulcer. Such an area of slough, having occurred, is relieved most quickly by excising completely the involved area and suturing the edges in the hope of primary union. (3) A small subcutaneous hæmorrhage may occur at the site of injection after the needle is withdrawn. This results in a black and blue spot and is due to the fact that the vein walls in such an individual are particularly fragile, so that they tear readily and permit hæmorrhage into the surrounding loose tissue. (4) Emboli are reported. A piece of the clot breaks off, is carried to the right heart, from there through the pulmonary circulation to the lung, where it lodges, resulting in pulmonary embolism, a dangerous complication, which is, fortunately, very rare and which has been discussed above.

Ulcers: Varicose veins untreated do not improve, but rather become slowly and steadily worse, and are likely to be followed by disabled sequelæ, the worst of which are re-

peated cellulitis and ulceration. It may be well to discuss briefly at this point the nature of these ulcers. The presence of varicose veins results in an impoverished blood supply to the skin of the leg, so that slight injury precipitates ulceration, which is slow to heal. Infection readily lodges in the devitalized tissues and the ulcer is soon surrounded by a zone of cellulitis, which constitutes a real source of danger as well as causing considerable pain and suffering, and which is followed by further fibrosis and further difficulty in healing. There are, then, many factors which contribute to the chronicity of such ulcers, and attention must be directed toward the correction of all contributory factors if intractible ulcers are to be healed and kept healed. The cure of ulcer necessitates several stages, which must be faithfully followed through if the desired goal is to be attained. While the injection of remaining varicose veins is essential, the injection of veins alone will not often result in cure. The ulcers are dressed with antiseptic dressings until clean. Eusol or hygeon, diluted and applied cold twice daily, have proven efficaceous. The use of ointments is to be condemned, because they result in maceration of tissue, spread of infection, and the establishment of further chronicity. When the ulcer is clean a circular Unna's paste stocking is applied from the base of the toes to the tuberosity of the tibia. This is put on first thing in the morning when oedema is at a minimum, and is left on for five weeks. The secretion from the ulcer, which collects under the paste, is of actual curative value to the ulcer. It is usually necessary to renew the cast once or twice at intervals of five weeks before healing is complete.

Operations: Operative surgery has a place in the curing of some ulcers, particularly those complicated by fibrosis, scaring, lymph-oedema, or arteriosclerosis, which are not healed by the procedures outlined above. Skin grafting will cover quickly a large granulating surface and so avoid loss of time and further fibrosis. Division of the saphenous nerve will relieve the pain of irritable ulcers lying within the saphenous nerve distribution, thereby permitting adequate dressings, and will also improve the blood supply to some degree. Lumbar sympathectomy will improve the blood supply of the whole leg, and in selected cases will relieve pain, diminish oedema, and improve blood flow, thereby facilitating healing or improving the bed so that full thickness flap grafts may survive.

Conclusions: It has been the purpose of this article to draw attention to a prompt and efficient treatment which has recently been made available for an affliction that has long presented a tedious and unsatisfactory problem to doctors, as well as distressing the sufferer physically, economically and psychologically; and to indicate that further progress in the handling of this disease and its complications is still to be expected.

*Marketing Mass Education**

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Many discussions pertaining to health education lead early in their course to confusion of thought because the phase of the subject discussed is not made clear at the outset. To avoid this difficulty the Public Health Education Section of the American Public Health Association several years ago, proposed a terminology for common use. Phraseology was then recommended to define three types of public health educational activity:

1. The formal academic instruction given to students of health was designated as "public health training." (Two different types of training are actually embraced under the terminology "public health training." On the one hand it includes the curricular courses designed for those who are studying to equip themselves as public health workers of one type or another, i.e., public health nurses, engineers, epidemiologists, etc.; and on the other hand, it includes the incidental training in hygiene or public health given to those who may later become auxiliary aids in the public health campaign, for example, teachers, social workers, and physicians.)

2. The training of children in the school and elsewhere in health habits and the principles of hygiene and public health was designated as "child health education," and this term has become well established.

3. The less formal activities directed to the education of the adult population were designated "popular health instruction," phraseology which has not been widely accepted. The implication here that you cannot educate the mass but only instruct it suggests defeat at the outset.

The subject of this paper cuts somewhat across all three of these distinctive lines of endeavour. In the main, however, it concerns adult health education and child health education outside the classroom. Because neither of the fields indicated, singly or together, serve to emphasize the extent of the problem here in mind (its scope and the methods it necessitates being far beyond those commonly visualised) we have borrowed from contemporary popular educators in China the term "mass education."

By "mass education in health," is meant the dissemination among the whole population of knowledge gained by the technical worker in the field and laboratory to the end that this knowledge may be applied individually and collectively for the prevention of disease, the postponement of death, and the building up of a vigorously healthy population.

Failure to discriminate between the terms "hygiene" and "public health" also results in confusion at times. The one concerns the individual and his personal acts. The other concerns the individual only as a unit of society and his part in the collective acts of the group. Mass health education is concerned with both hygiene and public health and needs to distinguish between them in formulating its programmes.

It is not necessary perhaps here to dwell on the importance of public health education. But there have been times in these counsels when the importance of adult education has been allowed to become obscured by

(*Read before the Public Health Education Section of the American Public Health Association at the Sixtieth Annual Meeting at Montreal, Canada, September 16, 1931.)

emphasis on child health education. Adult education has been considered, when at all, chiefly as instruction in personal hygiene temporarily necessary to correct earlier deficiencies in child health education. Some would have us believe that if we could only thoroughly train one generation of children the necessity for adult health education would thereupon cease. The child is father to the man but the man is also father to the child. And this relationship has significant implications for health educators. In a diphtheria immunisation campaign or in such instances as the recent epidemic of infantile paralysis, prevention depends on adult understanding. In many instances, adult education provides society with its only opportunity for reaching the child.

Our whole programme of child education is dependent upon a certain amount of adult education, at the very least an amount sufficient to approve appropriations for teachers' salaries. Much educational effort with children is nullified by adult example. Indeed it is often nullified by the example of the teacher herself. It is doubtful if such nullification would be eliminated by offering adequate health education in their youth to future adults, parents and teachers.

How much of the content of one's early training is really carried into adult life? If the principles of health taught in childhood are to maintain their brilliant reality through all the amazing experiences and expanded horizons of adult life, the education of the individual must be everlastingly kept at, through grade school, high school, college, and mature adult life. What Bruce Barton says of advertising is equally true here: "You can't advertise today and quit tomorrow. You are not talking to a mass meeting—you're talking to a parade."

Even though we accept the importance of continuous mass education we have but rude implements with which to perform our tasks. We pour our time and money into posters, pamphlets, lectures, motion pictures and the radio, but we do not know very much about the relative educational value of these techniques. Who can say in what circumstances a radio talk is more effective and economical than a motion picture or when a poster will get better results than a pamphlet? Our measurement of the effectiveness of printed matter has too often been in terms of good printing, not in terms of life saving. This is as if the serologist strove for a serum which was crystal clear rather than for one which produced immunity. We cannot assume that because good printing pleases us it will please the public, or that if pleasing it will result in action. It may be that poor printing would save more lives than good printing.

Who can prove that his established use of any cherished medium has value in terms of life saving? What have we to show that the general health of a group exposed to prolonged health educational ministrations is any better off therefore? In our scant attempts to prove the value of our techniques, we have been content with subjective standards.

Largely because they have proceeded empirically, health educators are tolerated as step-children in the family of public health scientists. The laboratory man and the health officer have shown that toxin-antitoxin prevents diphtheria. The engineer has reliable statistical evidence that protection of a water supply decreases the incidence of typhoid fever. The public health nurse, the statistician, and the epidemiologist can produce convincing proof of the life saving value of their efforts. If mass education in health is to assume its legitimate place as a valuable routine in the public health campaign, equal in rank to vital statistics, bacteriology, or administration, the value of its methods must be proved, and newer

and more effective methods found. It may be no more difficult to establish scientifically the value of our educational techniques than it was to establish the value of present-day routines of communicable disease control. Those routines now appear to have been so easily proved, only because they have been proved.

The stern discipline of the laboratory and the brilliance of its results have attracted millions of dollars for research. As a result we have, compared with the past, a tremendous store of knowledge in preventive medicine. This is a store in the warehouse sense in that for the most part this knowledge is stored away in textbooks and journals, hidden from the layman among incomprehensible words and symbols and disguised with appalling statistics. Yet the research worker has performed his task. He has found the knowledge he sought. We have failed to make this knowledge available for the service of mankind. Production of knowledge has far outstripped consumption.

It is frequently argued that mass education in health cannot be effected because the public is not interested in health. This argument is fallacious. It is an alibi undoubtedly often used when salesmen first tried to introduce the "horseless carriage." But the science of public health is not in the "horseless carriage" stage. There is abundant evidence of a ready market for health. Last March we visited the boardwalk at Coney Island. In spite of bristling weather, we found crowds gathered to listen to so-called health lectures by modern medicine men. These spellbinders are known as pitchmen. They sell books, rubber exercisers, psylla seeds, ointments, tonics and whatnot. They appreciate the dollar and cents value of the health appeal and the visual method. They constitute a clearly defined group on the edge of the entertainment profession. The health appeal has been seized upon also by producers and distributors of all types of articles in selling their wares. Automobiles, soap, refrigerators, underwear, toys, books and, of course, all sorts of foods are urged upon us for their health value. That the health motif has such universal commercial importance would indicate sufficient popular interest to insure success in any mass movement in health education, if the proper techniques were used.

Hope for the future lies in our emergence from the empirical stage. With the help of our scientific confreres, we must test by objective standards our long established practices. But while undergoing such self-analysis, and perchance resultant housecleaning, we cannot profitably sit idly watching the parade go by. The problem of mass health education here outlined calls for the inauguration of methods adequate to the new concept which has already been caught by commercial interests.

That mass education, conceived in the broadest possible terms, is necessary to secure the utilisation by individuals and communities of available demonstrated health knowledge, which, applied, would lengthen life and make it happier, this group does not need to be persuaded. Any methods, new or old, which will help to raise the health intelligence of the masses, this group will welcome. Proponents of visual methods of health instruction believe that wider use in America of the museum method, its value in other fields long since well established, will be a means of reaching thousands of individuals who are now indifferent to other appeals.

The museum of hygiene has demonstrated its success in Germany and elsewhere. As a museum it is not merely a repository of historical objects and data but a true educational institution. It is fundamentally a permanent exhibition of devices cleverly arranged to command interest and crystallise understanding.

Such an institution would draw its elements from many sources. It would be equipped with workshops, research laboratories, lecture rooms, a library, broadcasting studio and auditorium, in addition to spacious exhibition halls. It would serve as a centre for research, experimentation and demonstration in visual and other unexplored methods for disseminating health knowledge.

There is probably no better existing model for such an institution than the Deutsches Hygiene Museum in Dresden. A museum like that in Dresden, adapted to American needs and medical standards, would be an important adjunct in spreading health knowledge among the masses, as well as in offering health education in elementary and secondary schools. It would also be a valuable aid in teaching hygiene in schools of medicine. For industry, as well, such visual instruction as only a museum could provide would be of inestimable benefit in instructing workers in accident prevention and health preservation.

A suitable building for such a museum would have ample proportions, easy accessibility, and possibilities for future enlargement. Among the exhibits would be wax, glass and plaster models, charts, and posters. They would visualise all health problems related to the more common diseases in a manner so graphic and dramatic as to command the attention of the average layman and be readily understood by him. They would provide instruction on the structure and functions of the various parts of the body. They would illustrate such subjects as biology, personal hygiene, mental hygiene, care of the teeth, nutrition, prenatal, postnatal, and child care, communicable disease control, tuberculosis, venereal diseases, tropical diseases, hygiene of work and the protection of the worker.

The Deutsches Hygiene Museum began its existence in 1911 in connection with the first International Hygiene Exhibition. In 1930,① the opening of a new and spacious permanent building for the Museum served as an occasion for holding in Dresden the second International Hygiene Exhibition, an event which was repeated in the summer of 1931. The permanent exhibits which this new building houses are the last word in visual health instruction. The charts, specimens, models and apparatus used are striking in design and compelling in interest.

A unique feature of many of the displays is their movability, that is, many models are so arranged that the museum visitor may operate them by turning a crank, pushing a lever or touching a button. This not only excites curiosity but compels attention and probably assures that the lesson of these particular displays at least will be remembered. These devices are most valuable also in attracting visitors to the museum.

A determined and highly successful effort has been made to keep all descriptive texts in the simplest language. The deadly seriousness which so often marks the effort to portray scientific information is absent to a large extent. Indeed, many of the charts and legends are quite droll, and this effect has been achieved without sacrifice of professional standards.

The German museum probably goes further than public health workers in America would find it judicious to go in its emphasis on physiology and personal hygiene at the expense of community hygiene. It has, however, successfully maintained a balance between the various special hygienes. Such an exhibit gives to the man in the street a means of separating the true from the false and differentiating between the important and the trivial in the health propaganda to which he is subjected

(①Dunham, George C. The International Hygiene Exhibition, A.J.P.H., XXI, 1: 1 (Jan.), 1931.)

today from a variety of special interests.

Such a museum established in a large city in America might well become the headquarters for an extensive educational programme comprising both intramural and extramural activities. Among the intramural activities there would be lectures based on exhibits; radio broadcasts as dramatic in their way as the exhibits themselves; specially prepared exhibits on subjects of timely interest, such as influenza and infantile paralysis; and regular courses in hygiene and health education in co-operation with local schools and universities.

If the full value of the museum were to be realised, however, its activities could not be confined to its own building, or its home community. It would, for example, develop small portable loan exhibits for which there is an ever-present demand. Official and voluntary public health agencies have now neither the funds nor adequate experience in exhibit technique to provide sufficient valuable material of this type. Travelling exhibits such as the motorised exhibits of the German museum might well be utilised. In co-operation with state health departments, a number of which are already utilising traveling exhibits, this would provide an admirable method of reaching rural populations. In time these temporary exhibitions might stimulate the development of a number of permanent museums, locally financed.

The question of financing such developments is one that we do not propose to raise here. Support has been forthcoming in the past for worthwhile projects. And if professional health educators in America earnestly desire such institutes for health education, and adequately voice that desire, undoubtedly support for them may be had in the not too distant future.

If we are to reach the masses we must enlarge our view of the size of the job that confronts us. We cannot leave off with any temporary popularisation of a few simple ideas. The task must be institutionalised. All phases of the health education movement must be utilised in concerted effort. New and effectual methods must be devised and continuously utilised in educating the whole mass of the population, generation upon generation, as to the importance of achieving, and the methods for achieving that summit of racial well-being which the researches of pioneers have made distantly visible. It is believed that museums of hygiene would serve as permanent centres for research and experimentation in health educational methods and as a continual inspiration to reference sources for health educators. The concept of a national network of such institutions, serving in concert as a far flung, permanent and living force for the dissemination of health knowledge among the masses, is noble in purpose and inspiring to contemplate.

(American Journal of Public Health, January, 1932.)

Seaside Bathing

About 200 years ago someone discovered the seaside as a health resort. The discovery was exploited. Seaside hospitals were built in the nineteenth century. And at the present time the shores of many countries are punctuated by therapeutic establishments and countless hotels and lodgings for the healthy and for convalescents. Every year millions trek from the towns to the seashore for their summer holidays.

Some of these millions are carefully supervised. There are the definitely tuberculous, for example. They are medically examined at home, and on reaching the seaside they are usually admitted to special institutions under the control of doctors who have specialised in tuberculosis. So far so good.

But what of the tens of thousands of delicate children sent every year to the seaside without any medical supervision whatever? The parents often have a blind belief, amounting sometimes to an obsession, that if only they can save enough money to send their delicate child to the seaside for a few weeks in the summer, he or she is bound to return full of radiant health and energy. The seaside is in their eyes almost as unerringly effective as a penny-in-the-slot machine.

So off the children go. They may be nervous, rheumatic or subject to catarrhs. Their circulation may be so defective that exposure to the cold turns them white and blue. But they are often indiscriminately herded with robust and perfectly healthy children, and made to follow the standard conventions of the seaside in the summer.

What are these? The child is hustled into the water irrespective of its temperature, of the weather, without any gradual preparation and hardening. Several baths a day, each much too lengthy, are varied by endless paddling by the seashore in the flimsiest of garments though the wind may be high and the day cloudy. It is doubtful if even the most robust children benefit from this Spartan treatment. The rest suffer, some only temporarily, others permanently.

The remedies for this unsatisfactory state of affairs begin at home. Parents may find it advisable to consult their doctors, and the suitability of each child for a seaside holiday may be discussed with him. The discussion may end in the whole family spending its summer holidays inland, in the mountains, perhaps. Or it may end in the family going to the seaside, but with a string of injunctions and restrictions to be practised by its more delicate members.

Arrived at the seaside, the family may find it has been fortunate enough to choose a resort which has studied this problem carefully and spent much money on finding solutions to it. Some resorts have constructed shallow, salt-water bathing pools protected against the wind, where the temperature of the water is several degrees above that of the sea. Other resorts provide special hot sea-baths for those who are unfit to stand the rigours of ordinary sea bathing. Others provide shelters in which the bather can restore his circulation by hot drinks and hot foot-baths. Still others publish rules and hints for bathing suitable for the climatic conditions of each place.

All these provisions and precautions show that we are beginning to learn the object lesson provided by the poor child, unclimatised and unwilling, who is hurried off into the sea, regardless of its temperature, and is left there till chilled to the marrow! But we are only beginning. Any thoughtful and observant person who spends an hour or two on almost any beach will not fail to discover some mortals, adults as well as children, trying to look well and happy, but utterly failing to do so. How can they look well if their

cheeks are white and their lips are blue? And how can they feel happy if they are shivering all the time, from top to toe?

Some families may find a useful compromise in taking quarters a few miles inland. Here they are out of earshot of the sounds of the sea—sounds which are disturbing enough to provoke troublesome sleeplessness in some cases.

The journey, only on sunny days, of a few miles to the sea is an automatic check on the unrationed bathing and paddling in which those children are tempted to indulge who live within a few yards of the sea.

In many cases the parents would do well to secure the advice of a doctor on the spot. Medical practitioners in seaside resorts have a unique knowledge of their dangers as well as of their advantages. Summer after summer they have had to deal with the crop of gastro-intestinal disturbances, bronchitis, rheumatic and other ailments which indiscriminate sea bathing yields. So they are well qualified to deal with a problem which has, as a matter of fact, become so insistent that a special discussion was devoted to it in 1931 by the British Medical Association at its annual meeting at Eastbourne on the south coast of England.

The publicity given to this problem has already helped materially towards its solution. Parents and others have only to be taught that shivering, blue and white children on the seashore are unwell and unhappy and that there are simple remedies for this state of affairs, and in due course we shall find these children pink and well. The blue and white child is not an essential and inevitable feature of the seashore. He is just a reminder that "someone has blundered."

(Published by courtesy of the Secretariat of the League of Red Cross Societies.)

Recent Advances in Obstetrics—Concluded

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The Post-Partum Period

The period following delivery is another field of preventive medicine that should be developed more thoroughly. Every obstetrical patient should be treated with the same careful aseptic technique, as a patient requiring major surgery. Antenatally, foci of infection in teeth, tonsils, sinuses, kidneys should be cleared up. Every precaution should be employed to prevent infection during delivery, by contamination or by the introduction of pathogenic bacteria into the birth canal and no carelessness should be permitted to contaminate the patient as soon as she reaches her bed. Neither doctor, nurse nor other attendant with any infection of the nose and throat or body, should be permitted in the hospital ward. Sterile vulva pads and pitcher irrigations guard the open wound, prevent infection and add cleanliness and comfort. Conservative treatment with rest, food, sunshine, posture for drainage, ergot and good nursing care will yield the best results.

Sleep and Pain, morphia or codeine are good following delivery for the necessary relief of pain. Sleep should be produced if necessary by a sedative, especially for the first three nights.

Bladder and Bowels: Catheterize, completely, after twelve hours, only if necessary after all attempts to induce have failed. Mineral oil morning and night activate the bowels or an occasional S.S. enema.

Exercise and Posture: With free movement in bed accomplish four things: Drainage—leading to less infection, better circulation—leading to better involution—prevention of thrombosis and a general improvement of the musele tone. A back rest on the third day, knee-chest position each morning after the sixth day,

bed calesthenics, out of bed on the tenth day.

Examination is made previous to leaving the hospital on the fourteenth day. Backache with longer bleeding suggest retroversion and may require pessary insertion. Subinvolution and cervical tears are considered. A final examination is made at end of six weeks, including blood pressure, urinalysis, blood count, if necessary, weight and bimanual pelvic examination.

Intermediate Period: The young mother when arriving home is closely confined with a new responsibility. She needs intelligent help. Her nursing problems can be dealt best with by a well-trained nurse, for a time, who is in touch with the obstetrician, and here in Canada fortunate indeed is she, who is in touch with the Victorian Order of Nurses. A practical nurse is sometimes competent, relatives are often unaccustomed to present day routine and technique.

Complications

Hemorrhage Vaginal: The three great causes of maternal deaths in obstetrics are hemorrhage, infection and toxemia. Vaginal hemorrhage may be prevented by good anaesthesia, by prophylactic forceps delivery, or with episiotomy, after the head has reached a safe level, to prevent uterine atony and maternal or fetal exhaustion; making certain of no retention of placenta, membranes or clots, by immediate repair of cervical or perineal laceration, by giving pituitrin immediately after birth of baby, by fundus held immediately and massaged if necessary, by administering pituitrin and ergot, by packing uterus if necessary, by glucose intravenous or transfusion, if indicated. In anemia the blood should be typed before delivery.

Puerperal Sepsis: Prevention always outweighs cure. Avoid contaminating the patient. Isolation, with good symptomatic nursing, fresh air and sunlight, Fowler ducubitus with change of position, forced water drinking, easily digested food, tonics, ice, narcotics, assisted by transfusions, scarlet fever antitoxin, various intravenous antiseptics or milk injections intramuscularly, help.

Shock: Regardless of cause — hemorrhage or protracted delivery attempts, requires instant proper nursing and medical treatment to save life—lower patient's head and shoulders, cover with hot blankets plus hot water bottles, stimulating hypos, with sedative-morphia, intravenous of gum-glucose preferable or blood transfusion or glucose or submammary saline, while waiting.

Pituitrin is one of the most dangerous weapons used in obstetrics when in indiscriminate hands, but when administered judicially and cautiously in small and frequently repeated doses before delivery, offers a safe and affective method of inducing and shortening labour at term. It is used extensively in the third stage after the birth, to aid placental separation and expulsion and to prevent hemorrhage. Thymophysin: A new combination of extract from the thymus and the posterior lobe of the pituitary is used to hasten uterine contractions but is found unsatisfactory, generally.

The Newborn

Intracranial Hemorrhage in the Newborn is best treated with repeated lumbar punctures, blood transfusions, oxygen if necessary, careful nursing supervision, simulating premature care with little handling and breast milk by gavage.

Asphyxia Neonatorum: Due to pre-natal atelectasis, obstruction due to mucous exudate, meconium, or amniotic fluid or to anaesthesia, cord or central pressure, drugs, etc., is best treated with catheter or intratracheal tube, mouth and pharynx suction, then mouth to mouth insufflation, or inhalation from a small cylinder apparatus of a mixture of oxygen and 7% CO^2 with mask over face and insufflated under pressure, continued until respiration is established or until the heart has ceased to beat and cynosis has developed.

This inhalation should be given several times a day for 5-10 minutes for several days, to assure full dilatation of the lungs, so, to save many children who now die of pneumonia, consequent upon continuing atelectasis during the neonatal period. Hot and cold tubs are not to be overlooked.

Persistent Thymus is suggested clinically in the first few days after birth by (1) crowing breathing—with brassy cough due to pressure on the recurrent laranygeal nerve, (2) blue spells—due to breath holding or pressure, (3) difficulty in nursing, (4) convulsions, (5) sudden death.

Treatment—immediate, x-ray radiation at weekly intervals for 2-4 times—sometimes 2-3 series are required. It is more common in males, 6-1.

Differential diagnosis is atelectasis, cerebral hemorrhage and congenital heart malformation.

Icterus Neonatorum can be appreciably eliminated by clamping and tying the cord immediately after birth, so lessening the amount of hemolysing placental or cord blood getting into the newborn circulation producing this jaundice. Familial jaundice is best treated with 8 c.c. of whole blood intramuscularly or with injections of mother's serum.

Pemphigus Neonatorum, the bugbear of hospitals throughout the world, is sometimes present in the newborn at birth. It appears to be carried from hospital to hospital and from pustular infection on some one or thing coming in contact with the baby. Prophylaxis is the best treatment; all healthy babies should be kept isolated in the nursery, to the extent of only being attended by the nurse and being brought individually to an examining room for inspection. As a preventative, six hours after birth the newborn is first given a bath with sterile water, followed by a bath of 1-6000 biniodide, then with a bath of 1¼% copper oleate solution. During its stay in the hospital this copper oleate bath is given daily; no soap is used. On discovery of any pustule the case is isolated, the pustules are immediately broken and touched up with 5% tincture of iodine, baby is kept naked and dry under a heater, with calomel and starch powder applied.

Supplementary Feeding: The daily weighing of baby, with careful notation of the weight and immediate use of good nourishing supplementary feeding, or weaning, where necessitated, before too much weight has been lost, constitutes a great step in the lessening of infant mortality.

Early Pregnancy Test

Is one of the most important achievements in obstetrics in recent times. The Friedman Test for early pregnancy is done by the injection intravenously of small amounts of urine from pregnant women, after about the third week, into an adult female rabbit, which induces ovulation or recently ruptured Graafian follicles, seen macroscopically in this animal, in thirty hours time. This procedure will likely supplant the original Ascheim-Zondek Test where immature female mice are used and the results are not seen for five days time. The test is certain in practically all cases and has been recommended also for the diagnosis of Hydatidiform Mole and Chorio-Epitholioma, where suspected, as it gives a positive result in these conditions too. If, after the removal of the new growths, the test becomes negative, a good prognosis is given; if, however, the test remains positive for a long time, it is indicated that all the disease has not been removed, or that a Hydatidiform Mole has become converted into a Chorio-Epithelioma or that a recurrence has taken place.

Birth Control

It seems, is a doctrine which applies to the wrong element of the population, resulting in the gradual extinction of the old families, while the more precocious Europeans with ten children to the family, will, in a few generations constitute numerically the first families of the nation.

Unfortunately, knowledge given in these cases, in which it may seem necessary, is not kept secret by the immediate recipients, but is imparted to others who have no just excuse for the avoidance of childbearing. We are morally responsible for imparting knowledge, which we know will be used for evil. The training in sex education should begin in the school in a healthy, clean study of the matter as part of biology and advice should be restricted to individual cases as a medical and not as an economic measure.

Rectal Ether Analgesia in Labour

Of recent years great success has attended the efforts to relieve the pain during labour. Patients are now demanding relief and this is as it should be. Too long has the agony accompanying childbirth been looked upon as "nature taking its course." It seems that at last woman is coming into her own in this regard. While neither patient nor surgeon would think of an appendix removal without complete relief from pain—a relief for a brief space of perhaps fifteen minutes or more, does it not seem ridiculous to allow unfortunate women to undergo the torment of the damned for hours or maybe days in labour? By this relief from suffering in childbirth, the world should be better, the children healthier, the mothers happier and much of the illness and invalidism of the later years of life would be avoided.

Rectal Ether Analgesia is induced by the combined result of several drugs working together. The induction involves three or more hypodermic injections and one or more rectal instillations. In practically all cases it affords relief to the agonising ordeal and in a goodly number of cases does offer painless childbirth.

Before beginning the treatment, the obstetrician should carefully explain to the patient that her cooperation will result in the relief of pain, that she will fall asleep and likely not waken until after the baby is born. The simple technique is as follows: The perineum is prepared and an S.S. enema given, if not too far advanced. When the pains are coming at five-minute intervals and the cervix is at least two fingers dilated, the patient is given, in the gluteal region, the first hypodermic of morphia, gr. ¼ in 2 c.c. of a 50% solution of magnesium sulphate (obtainable by ampule). The patient is advised to try to remain quiet, go to sleep; cotton pledgets are placed in her ears, the eyes are covered with a towel, the room is darkened, curtains are drawn or lights subdued. The window is closed, all manipulations are gently and quietly done, any talk is in whispers, the patient, if talkative, is not answered. The instillation is given in about twenty minutes, for which the patient is turned on her left side with knees flexed and the area surrounding the anus is smeared with vaseline, to assure no irritation if expelled. The instillation apparatus consists of a four oz. enamel funnel attached to twenty inches of rubber tubing connected with a glass connecting tip to a stiff French catheter No. 22. The ether mixture consists of quinine, alcohol, ether and liquid petrolatum. A glass of four oz. of warmed liquid petrolatum is also at hand. On commencing the instillation, about one oz. of the liquid petrolatum is poured into the funnel, and just as it runs out of the catheter, the tubing is pinched off.

Method of Instillation: The doctor inserts the vaselined, gloved, right index finger into the rectum and the lubricated French catheter is followed along this for eight inches or more to assure its being inserted above the presenting part, otherwise, if the catheter curls up, the instillation will be expelled. The nurse now pours the ether mixture of four ozs. into the funnel and it is slowly run by gravity into the rectum between pains. During a pain the tube should be clamped, the patient is advised to try and "tighten up" on the rectum, not to press down and to breathe

through her open mouth and make every effort to retain the instillation. In larger, stronger or excitable patients more than four ozs. is best used. When the funnel is almost empty of the other mixture, quickly add an oz. or more of the liquid petrolatum to assure the patient's getting all the solution and to prevent entrance of air. The nurse then clamps or squeezes the tube and with a large folded towel, presses strongly on the perineum to assist in the retention, especially during a strong pain; then the catheter is quickly but gently withdrawn. Towel pressure for at least ten minutes is one of the most important features on which the success of the analgesia depends. The intelligent co-operation of the nurse or attendant in maintaining silence and leaving the patient alone, not holding her hand or rubbing her back, is one of the key notes of success. After the instillation the patient is given the second hypodermic of 2 c.c. 50% magnesium sulphate solution, the synergist, to prolong the action of the ether. The patient may be turned on her back or left on the side and she is made warm with blankets. In a half hour's time the third hypodermic of magnesium sulphate solution, to deepen the effect, is given.

Results of the medication vary from a sedative effect to analgesia, with unconsciousness and complete amnesia. While instilling, the patient may drowsily remark the taste of ether in the mouth—often, even before the whole instillation is given, the patient falls asleep, pain is eliminated, labour progresses, the contractions ensue, sometimes accompanied by slight murmuring or restlessness. After she remembers nothing from the time of first instillation until she awakens in her room after the delivery is all over. Sometimes one instillation is sufficient to obtain quite wonderful relief—relief to the patient and also a very satisfying relief to the obstetrician and to the nurses. After instillation, relief is obtained for varying lengths of time, according to the patient's nervous makeup, to the progress of the labour and to the ability of the nurse: a quiet, stable patient generally gets better relief than the neurotic or non-co-operative one. Freedom from complaints of pain may be from three to six hours ordinarily, accordingly, but the instillation may be repeated if necessary at intervals of three hours or more, three, four or five times with absolute safety. A vaginal or rectal examination may be done in fifteen minutes or better later, to avoid stimulation of expulsion and disturbance. During the progress of the case the nurse may examine the patient for progress; that is, perineal bulging, but not unnecessarily. On moving the patient on the stretcher, she should be lifted and her aid not sought; to prevent rousing, her eyes should be protected against a strong electric light, and the same quiet stillness maintained during her preparation and delivery.

After using this method of analgesia one is conscious of a certain feeling of guilt on hearing the shrieking agony of the unrelieved in the labour room. Today women may be carried through labour with little murmuring and no shrieks. With this rectal synergistic analgesia there is absolute safety to both mother and child. In uterine inertia, as is self-evident, the instillation is contra-indicated. In any case where labour stops, you must simply wait until it begins again and repeat the technique when you know labour is advancing. It is seldom, however, that labour stops or is delayed by the instillation if given at the proper time—not too early. Sometimes quinine gr. v. or gr. x. in capsule may be given by mouth before the instillation or between instillations to promote contractions. This ether-oil method can be used in all normal cases, the same in the primipara as in the multipara, in dystocia, in induction, in toxemias, in cardiacs, in nephritics and in tuberculous conditions. From an economical standpoint this method

does away with considerable expense and can be used in the home with good results and does not require the services of an anaesthetist or the use of an expensive anaesthetic. It does not require more nursing or medical attendance than is necessary for the safe conduct of labour anywhere. This synergistic method is particularly adapted for the patient who has passed through difficult and painful labours before and is in persistent terror of the coming pain. The patient's knowledge during the antenatal period that at the end she is assured of being relieved of pain is invaluable—she does not look ahead in fear and dread of the ordeal. Her energy is conserved as she has not been shocked. She not only looks infinitely better, but she feels much better and may get out of bed earlier than the one who has not been so fortunate. The patient, with her pains alleviated, may be under the anaesthetic during the whole labour of many hours. There is no increase in operative deliveries, in post-partum hemorrhage or in the stillbirth rate; there is better relaxation and there is no interference in any way with the normal process of labour.

As to inconvenience, most of the so-called disadvantages are due to faulty technique, the commonest of which is probably the improper catheter insertion, due to failure to insert the French catheter above the presenting part—it curls up and with the advent of a pain the retention enema is expelled. Occasionally an unexpelled preceding S.S. enema may cause expulsion and necessitate another instillation. The instillation must be given best before the patient is too far advanced in labour or is fully dilated—before the pains are too strong and bearing down, as otherwise it is impossible to subdue the pains and difficulty is reached in the patient retaining the instillation. The towel perineal pressure for ten or fifteen minutes is essential. Sometimes the patient complains of a slight burning sensation in the anal region immediately after the rectal instillation. Well vaselining the part will prevent this, but if the technique is followed, no inflammation, of even a mild type, occurs. Extensive hemorrhoids, without abrasions, are not affected and do not contraindicate this method. Poor results, however, undoubtedly occur from attempts at modifying or entirely disregarding the simple rules of administration. Minor symptoms of ringing in the ears and temporary deafness, as is ordinarily resultant from quinine, is sometimes observed. The patient in the home should be carefully watched, especially the multipara, as labour may advance and terminate very quickly while the patient is fast asleep. While a nurse is preferable at home, an ordinary attendant is quite satisfactory, as the patient practically never becomes noisy or troublesome, necessitating extra help. Vomiting is occasional, but not more than with any other form of anaesthesia. This method takes a little time, but the very desirable results obtained will more than compensate the obstetrician when the new mother voices her appreciation.

In my series of 540 private cases using this method of rectal analgesia, I have yet to see any ill effect. Practically all the cases were in hospital, in each of which I have had the excellent co-operation of the nursing staffs. In 98% of 540 cases, pain was greatly alleviated: of these, 67% had practically no pain, while 31% obtained very considerable relief, but not to be graded perfect, and in 2%, due to instillation expulsion or to labour being too far advanced, the patient obtained no relief from this method.

Where such safe relief is obtainable, this method can be recommended for more universal use, both in hospital and in home deliveries.

The word of the patient after delivery is the best criterion as to its worth and the finest recommendation that can be given this method of pain relief.

(Address read by invitation before the Registered Nurses Association of Ontario at Ottawa, January 28th, 1932.)

A Brief Resume of the Report of the Lancet Commission on Nursing

By MARION LINDEBURGH, Assistant Director, McGill University, Montreal, Que.

An editorial appeared in *The Canadian Nurse* (October, 1931), which presented initial information regarding the appointment, aims and function of the Lancet Commission on Nursing in Great Britain. This article referred to data made available in the first and second interim reports of the Commission, as published in the February and August issues of The Lancet during last year. The final report is now completed and may be obtained from The Lancet, Ltd., 7 Adam Street, Adelphi, London, W.C.2. The price, including postage, is 2s. 9d.

It is not the objective, in presenting this review, to undertake a critical or comparative analysis of the Lancet Commission Report in relation to the Survey Report of Nursing Education in Canada, but rather to indicate certain significant features within the Report itself which seem to constitute the most immediate problems in the nursing situation in the British Isles. The two reports present many points of similarity and many points of contrast. A study of these comparative and contrasting features should establish a mutual interest and breadth of understanding relating to nursing problems in Great Britain and Canada.

It is of unique significance that at approximately the same date nursing has reached a crisis in its development in Canada, Great Britain and the United States which has demanded an analysis of existing difficulties. An urgent need has arisen in the hospital nursing school for reconstruction in the administration and function of its two major responsibilities, nursing education and nursing service.

In contrast to the immediate nursing problems of "over-production" in Canada, the Lancet Commission was appointed "to inquire into the reasons for the shortage of candidates, trained and untrained, for nursing the sick in general and special hospitals throughout the country, and to offer suggestions for making the service more attractive to women suitable for this necessary work."

The Commission, under the chairmanship of the Earl of Crawford and Balcarres, P.C., K.T., F.R.S., was appointed in December, 1930. The personnel of the Commission was representative of the nursing and medical professions, the field of secondary and college education, social economics and hospital administration. The personnel and function of this committee is in contrast to that of the Canadian Survey, in which a committee, composed of members of the Canadian Nurses Association and the Canadian Medical Association, assigned the study to an educational survey expert who, as Director of the Survey, became solely responsible for the analysis and the final recommendations.

The Lancet Commission was extremely fortunate in securing the cooperation of Dr. Bradford Hill, of the Department of Epidemiology and Vital Statistics, London School of Hygiene and Tropical Medicine. To Dr. Hill is given the credit for the careful compilation of data and statistical presentation. The Commission held its first meeting on December 8th, 1930, and during the following fourteen months involved in making the survey, twenty-four meetings were held.

As in Canada, the Lancet Commission adopted the questionnaire method. There were, in all, three questionnaires, and it is significant

to note that they related directly or indirectly to the problem of hospital nursing service. Unlike our survey, which is focussed primarily upon problems relating to the education of the nurse, the English study is avowedly concerned with the question of the actual care of the patient in the hospital ward. To quote from the Report, "To restore the popularity of nursing among educated girls has been the chief objective of our inquiries. The economic and administrative difficulties of hospitals, the vocational ideals of some nurses, and the professional aspiration of others concern us only in so far as they promote or hinder our object of inducing enough educated girls to come forward and dispel anxiety about the nursing care of the sick in hospitals. . . It is useless to provide hospitals and doctors for the sick, unless an adequate nursing service can be assured."

A sub-committee was appointed to draft the first questionnaire. Its content of thirty-six questions was selected to ascertain (1) Whether shortage related to candidates for training or to trained nurses for staff positions—or both; (2) Whether shortage was felt in hospitals approved by the General Nursing Council as well as by those not so approved. This questionnaire was forwarded to responsible authorities in approved training centres, and a selected number of questions to hospitals not approved. Two further questionnaires were sent out, respectively, to trained nurses working in hospitals, and to a selected number of student nurses (known as "probationers" throughout their entire terms of training), with secondary school standing.

In addition, groups of girls still at school were questioned. The results of all these inquiries are summarised in the appendices of the Report. Response secured from questionnaires was such that information received on conditions in Scotland and Ireland was not sufficiently adequate to enable general conclusions to be formulated. Thus the Report in its final form deals only with conditions *in England and Wales*. Furthermore, the Report is based on data secured in the first half of 1931. The effect of the economic depression in England, as elsewhere, resulted in a sudden influx of applicants to hospitals which modified to considerable degree a situation which but six months previously demanded urgent attention. In this connection it must be noted that, regardless of the change that suddenly came about in the problem of shortage of candidates, the responses received from matrons, sisters, staff nurses and probationers were of such value as to convince the members of the Commission that there was still need for certain fundamental adjustments in hospital nursing schools which must be made in order that *desirable* candidates be secured and retained.

During the course of the survey Dr. Hill prepared two interim reports, presenting a statistical analysis of data secured up to date. No comments whatever were included in relation to conditions revealed. These reports were of specific value to the Commission in directing their future inquiries and in making available, to associations and individuals interested, the progress of the work of the Commission. The final Report presents a complete statement of findings in statistical form. Tables and graphical representations are clear and comprehensive. The major part of the Report deals with the Commission's interpretations of data secured, and the field of discussion is classified under twelve sections.

Recommendations are assembled under sections dealing with reasons for shortage of candidates and trained staff for general duty, and positions of leadership in nursing service. In the last section a well consolidated summary of recommendations is presented. The Commission emphasizes the fact that in making these recommendations attention has been confined to proposals which involve certain possible *adaptations*, rather

than with fundamental changes in the present system of hospital administration in which nursing schools are profitably maintained for the sole purpose of securing nursing service.

Following this general statement suggesting the aims, organisation and method of function adopted by the Lancet Commission, it would seem advisable to devote some attention to the nature of the response to the questionnaires, and the recommendations which follow.

Shortage of candidates, in quantity and quality, is clearly evident in returns of questionnaires. Taking the hospitals collectively, one-fifth of them fail to secure suitable candidates as "sisters" and one-half fail to secure staff nurses and probationers of the standard they require. Shortage is much less acute in the London voluntary hospitals than in other groups. The difficulty in securing properly qualified students is revealed in the fact that one-third of the hospitals will accept candidates who have not passed beyond the seventh standard of the elementary school. Real difficulty is experienced in securing candidates with secondary school education. The following extract of a report of an Education Committee of a certain county confirms this statement. "It is perhaps a little disappointing that only six girls out of seven hundred and forty took up nursing." A report from the heads of eight secondary schools shows that during the period of ten years the number of girls entering nursing was under fifty, an average of less than one candidate per year per school.

Replies received from probationers reveal fewer points in favour of nursing than were listed under objections. The following are some of the points of disfavour: limitation of opportunities for social life; shortness, irregularity and uncertainty of off-duty time; over work and fatigue; lectures during off-duty time; too much menial work; excessive responsibility before receiving adequate instruction; unnecessary restrictions and discipline in "Nurses' Home;" favouritism shown by the sisters to students; poorly cooked food; insufficient sleep; lack of interest shown by the hospital in the health and welfare of nurses; burden of work and study too great; narrowness of outlook and continuous "shop."

Answers to questionnaires received from staff nurses expressed many reasons for reluctance to remain in hospital positions. The following were mentioned the most frequently: poor salary—better remuneration in fields of specialisation in the community; long hours of work; lack of freedom during off-duty time (permission necessary if remaining out after ten or eleven p.m.); opportunity for social life no greater than that afforded to probationers; lack of recognition, on the part of authorities, of potential qualities of leadership—little opportunity for promotion.

Information from other sources revealed certain basic reasons which are influencing factors in retarding the professional growth of nursing in hospitals. The following are of special significance:

The profession still judged in terms of conditions of its past.

Fields of specialisation offering more favourable vocational opportunities.

The attitude of certain nursing members in authority who still hold to the belief that the nursing spirit and nursing skills have been *dimmed* by the introduction of the "curriculum" and who still adhere to long hours of faithful nursing service, predicting that less autocratic discipline and provision for greater social freedom would prove fatal to the profession.

The undemocratic attitude in professional relationships—students disparaged by their seniors, and sometimes rebuked before the patients.

The employment of untrained or partially trained women by doctors,

by hospitals, and by the public, is a source of grave dissatisfaction within the profession.

The gap between school leaving age and the age approved for entrance into nursing schools. In this connection the Report contains certain proposals and schemes to provide for continued secondary school education or preliminary employment, which would facilitate the selection of young women suitable for the profession. The College of Nursing favours the establishment of a pre-nursing course, in connection with certain recognised hospitals, and operated in co-operation with educational authorities, which would not only fill the gap but would provide a stronger educational background. A draft syllabus of such a proposed course appears in appendix V of the Report.

In view of the fact that twelve different classifications of hospitals were used, the data secured and tabulated in comprehensive tables and graphs indicates marked contrast in standards. Therefore the Commission has attempted to focus attention to the medial conditions of service in setting up recommendations. The following picture is presented by the Commission to suggest the average existing situation in approved schools:

"The candidate for nursing must be 18 or 19 years of age before she submits her application, though she may be accepted at 17 if she is willing to enter a hospital that is unable to give her a complete theoretical and practical training. She should have had, if she wishes to enter the voluntary hospital service, an education at a secondary school, and possession of the Matriculation or School-leaving certificate will assist her to gain an entry into one of the larger training schools. On the other hand, in the absence of a secondary education, she will have no difficulty in gaining admission to a municipal or mental hospital if her educational level is that of the seventh standard at an elementary school. Having secured admission to a hospital approved for training she will usually find herself provided with a separate bedroom; but in any hospital in which an approved course of training is not given it is probable that she must be content to share her room. She must, if she wishes to be fully qualified, undergo a three to four years' course of training and, concurrently with her ward work, must attend lectures, in the morning, afternoon, or evening, half of which she must attend in her off-duty time. Rarely will she be required to pay any fee for her training, and she will not, as a rule, be asked to bind herself to work for any further period after qualification in the hospital which has offered her her training. During her tuition she will be in receipt of a salary, ranging from £20 to £30 per annum in her first year to £30 to £40 in her final year. In addition she will be provided with her board and lodging, her uniform, and her laundry. When she becomes a staff nurse her initial salary will be £50 to £65 per annum, and should she become a Sister her salary will rise to between £70 to £85 and continue to increase by annual increments to, perhaps, £100 per annum. In two-thirds of the hospitals to which she may go after qualification she will be able to contribute to a superannuation scheme, and thus make some provision for her future.

"Her life will be an institutional one, and during her training at any rate she must, when she is allowed out, return to the nurses' home by 10 p.m., unless she has special permission to be later. After qualification her hour to return in some hospitals may be a later one, but her hours will be fixed, and she will not be provided with a latch-key. Within the nurses' home she will have a common room at her disposal, but, as a rule, she will not be allowed to introduce men guests. Facilities for indoor and outdoor recreation will be given her (especially tennis), and

she will usually be permitted to smoke in some part of the nurses' home. In return she will work from nine to ten hours per day from between 7-7.30 in the morning to 8-8.30 at night. During this day she will have half an hour off-duty for her lunch and her tea and, probably, a quarter of an hour to a half hour for an early lunch, while she will have a further two to three hours of free time daily. Weekly she will be allowed half a day or a whole day off, and she will usually be allowed some extra time off fortnightly or monthly. As a result her *average* working week on day duty will be between 55 and 64 hours. Annually she will be given (as a probationer) two to three weeks' holiday.

"With regard to making plans for the use of her off time, she may have as little as a month's notice of this annual holiday; her half-day or day off weekly she will know at the beginning of the week, or, less frequently, at the beginning of the month; her daily hours off she will know often only at the beginning of the same day.

"When she is on night duty her hours will be from 8-9 o'clock at night to 7.30-9 o'clock the next morning. Sometimes during this time she will be relieved and be given some free time away from the ward, but in an equal number of hospitals she will have to attend to her duties throughout the night. She will be on night duty for three months at a time, and during this period will be allowed two to four nights off per month in addition to coming to duty later on occasional evenings."

Recommendations are systematically formulated in connection with points of issue as revealed by the survey. The Commission has endeavoured to suggest measures which would meet the peculiar differences in general and special institutions. In all, 61 recommendations are presented. Space does not afford full publication, but the following are selected to indicate the nature and scope of the adjustments suggested:

"I. Conditions of service in the nursing profession should be altered in such a way as to attract a far larger proportion of those girls who in any case will stay at school till they are 18.

"V. Hospitals should realise that the nurses are paying indirectly if not directly for their training and that the onus rests on the hospitals to provide good facilities for such training including expert instruction during hours on duty. To this end a ward sister who has to train successive batches of students should be given extra remuneration, and some relief from other duties, for teaching in the wards.

"XII. We recommend the universal adoption of the College of Nursing scale of minimum salaries for posts higher than that of the ward sister. . . .

"XIV. All voluntary hospitals, institutions and associations employing nurses should participate in the Federated Superannuation Scheme for Nurses and Hospital Officers.

"XVII. Day Duty — the span of work should not exceed 13 hours.

"XX. Not less than three clear hours off duty independent of meal times should be allowed during the span every day.

"XXII. The hours of night duty should not exceed 57 in any week.

"XXVII. No nurse except a night sister engaged as a permanent officer, should be on night duty for more than three months in any year.

"XXX. The matron should have the power to suspend, but not to dismiss, a probationer pending investigation by a committee of the Board of Management.

"XXXI. A separate bedroom should be provided for each nurse. . . .

"XXXV. Off duty time should be arranged in advance, so that the probationer knows at least a week beforehand, between what hours she will be free on a given day.

"XXXVI. A probationer on day duty should be free to go out between the time she comes off, and bedtime, without special permission.

"XL. The preliminary state examination of the General Nursing Council should be divided into two parts: Part I. Anatomy, Physiology, Hygiene; Part II. Theory and Practice of Nursing.

"XLIV. Questions in the final state examinations for all parts of the register should be confined to nursing treatment, and should not involve systematic medicine, surgery, gynaecology, or psychiatry.

"XLVII. Sister tutors should not be required to undertake any duties other than those connected with education.

"XLIX. A redistribution between nurses and ward maids of the domestic work in the wards of hospitals is urgently required.

"LIII. Posts as staff nurse should be reserved for fully trained nurses.

"LIV. Hospitals which are not approved by the General Nursing Council should not seek to enlist probationers for training but should be staffed by trained nurses and domestic workers."

An editorial appears in the March issue of the British Journal of Nursing in which a criticism is presented regarding the recommendation concerning "registration" which suggests the placing of part of the "Preliminary State examination outside the control of the General Nursing Council." The principle of supreme importance underlying the Nurses Registration Acts in Great Britain is the admission to the State Register through the "One Portal." It is regretted within the profession that in mental hospitals there still exists two accepted forms of qualification; through the General Nursing Council and through a certificate issued by the Royal Medico-Psychological Association. Further regret is expressed, in that no recommendation is made by the Commission in connection with the Inspection of Nursing Schools by registered nurses as well as by medical practitioners.

A very real interest has been taken among nurses in the British Isles in the work of the Commission. During the study a memorandum of suggested changes was submitted to the Lancet Commission, for consideration, by a group of nurses, many of whom had followed the International Courses organised in London by the League of Red Cross Societies. Their concern as to the attitude toward nursing held, not only by the public, but by hospital authorities, is expressed in the character of their recommendations. Nursing leaders in England, as in America, are becoming strongly aware of the fact that nursing schools must be placed upon a more favourable financial and educational basis, in keeping with modern educational standards, if nursing is to receive professional recognition.

Nurses' Christian Fellowship

During the past few years there has been much improvement in the provision made for the intellectual and social needs of the student nurses, e.g., better teaching facilities and the shortening of the hours of duty. But what has been done for the spiritual needs of their lives? Oh, that leaders would arise in the profession to help nurses to satisfy that heart-hunger present in each one!

Is there any nurse who cannot remember when, in her training school days, she felt it difficult to adjust herself to the "new order of life," and how lonely she felt at times for the old associations in spiritual things, the old companions and places which had so richly helped her in the past—her church and the fellowship with Christian friends?

One came away from graduation, having gained a diploma, but with a sense of having lost something—that something which a nurse really needs to help her to go out into the world to minister to the suffering and afflicted, and to lift the fallen, in the practice of her profession.

That something can be described as "a consciousness of fellowship with Him, who is Redeemer and Creator."

During the past year a movement has been started to form a "Christian Fellowship for Nurses." It is believed that there are small groups of nurses in various cities throughout Canada who are meeting together from time to time in their own training schools, or perhaps outside of training schools, for the purpose of securing fellowship in spiritual things and by companionship to encourage and strengthen one another to maintain their hold on the vital things of life—those things pertaining to eternity.

In Toronto, during this past year, a group of nurses has been meeting together once a month (or oftener) for the purpose of Christian fellowship. Mrs. F. Noel Palmer, who is joint secretary with her husband, the Rev. F. Noel Palmer, of the Inter-Varsity Christian Fellowship of Canada, has been very kind in opening her home for meetings. Also Mrs. Maud Howe, secretary of the Canadian Christian Crusade, has opened her home and has given freely of her time. Both these ladies are standing whole-heartedly behind the movement and are the inspiration of the group.

While this group is organised similarly to the Inter-Varsity Christian Fellowship, the Nurses' Fellowship is organised and conducted by the nurses themselves. It is interdenominational. Its aim is to encourage individual and collective prayer and Bible study among nurses, graduates and students in training.

There is no detailed programme planned, but the guidance is sought from the Leader, the Lord and Saviour, Jesus Christ. Friendly informality and spirituality are the outstanding characteristics of the meetings. New acquaintances are made, with free interchange of experiences, hopes and aspirations; for some meetings special speakers are secured, at others the nurses' talent is used. They sing, have the reading of the Scriptures, receive requests for prayer, hear of answers to prayer, and then at the end of the meeting refreshments are served.

This delightful fellowship with one another is enjoyed, as all are "one in Christ Jesus."

The nurses realise the fact that union means strength; they would like to get in touch with others and hear how they are getting on. Perhaps others would be interested in starting something similar in their own groups. Correspondence is invited.—ETHEL E. CHILVERS, Reg.N., 278 Bloor Street East, Toronto, Ont.

A Symposium on the Administration of Student Field Work

[Editor's Note: For students enrolled in the Department of Public Health Nursing, University of Toronto, a continuous period of nine weeks of field work is arranged. The time is spent with two of three agencies: The Provincial Department of Health; The Municipal Department of Health, and The Victorian Order of Nurses. Prior to that period a conference of representatives providing field work is arranged by the Department of Public Health Nursing of the University of Toronto. This year a Symposium on the Administration of Student Field Work included several brief papers. A synopsis of these is published.]

I

Plans before the Field Work Period from the Standpoint of the Supervisor

By JESSIE M. WOODS,
District Superintendent, Department of Public Health, Toronto, Ont.

Selection of District: In planning for the field work of students, careful selection of the type of district is important; one that will give the student an opportunity for observing every type of activity carried on by the nurse and later for carrying on independent work; and one that will give as even a division as possible to school and district work. It is well to have the student carry on field work in a district where she will have contact with the independent, teachable type of family as well as with the more difficult type presenting social problems, where health teaching is carried on under difficulties.

Selection of Nurse to whom Student is Assigned: In choosing the nurse to whom students are to be assigned the following points should be kept in mind: the interest of the nurse in the work of students, her ability to teach, to plan and to direct their work. The nurses who have these qualifications, however, are not always the ones to whom students are assigned as their districts may not be the type best suited for field work.

Preparation of the Programme: The nurse should be notified well in advance that she is to have a student. A conference of the staff nurses selected and the superintendent should be held before the students arrive, to discuss the nurses' plans for direction of students' work and the supervision to be carried on by the staff nurse and superintendent in schools, district and child health centres.

A regular time for conference of the student and the superintendent, once a week if possible, should be arranged before the students arrive. The staff nurses having students should be prepared to be present at such conferences for part time at least, although this may not be possible for them every week. The superintendent should plan to see the student daily if possible and give her an opportunity to discuss individual cases or problems.

Obtaining Co-operation of Those who Contribute to the Programme: Nurses having students should explain previously to their school principals and teachers who the students are, why they come and what it is hoped to give them.

In the homes selected by the nurse for close follow-up work by the student it is well to prepare the family for the visits of a new nurse. It makes it much easier for the student and family if, on the first visit, the staff nurse is able to say, "This is the nurse who I told you would be visiting you for the next few weeks."

The district medical officer has a great deal to contribute in the way of information concerning the different activities carried on in school, district and child health centres and his help in making the field work of the student of more value should be asked. The child health centre physicians should be prepared for the students in their centres and asked to take time to explain to them the work of the centre.

The secretary of the Neighbourhood Workers' Association should also be notified that the students will be with the district staff and asked if she will tell the students, after they have been there for a few days, of the work of the Neighbourhood Workers' Association and their relationship to other social organisations.

The staff nurses, apart from those to whom students are assigned, should be asked to help the student in every way they can, to show an interest in her work and make her feel that, during the time that she is with them, she is one of the group.

II

Plans during the Field Work Period from the Standpoint of the Supervisor

By MARION STEVENS,
Supervisor, Victorian Order of Nurses, Toronto, Ont.

The success or failure of the student nurse in the field depends largely upon herself. The opportunity is open to her once she enters the district. After application to studies, her enthusiasm is keen, and she has high hopes that she may be able to apply her knowledge with a measure of success.

It lies within the power of those responsible for her instruction and guidance to preserve and increase that interest. The supervisor may assist, but the real opportunity is given to the staff nurse who works so closely with the student.

Plans have been made weeks in advance after careful consideration and it is the opportunity of the administrator to assist the staff nurse in the meeting of these requirements. The plan is a device which aims towards purposeful achievement and it has been made simple to allow necessary freedom.

For a week or ten days the student should be left with the staff nurse, to find her ground. All types of visits should be observed. Early independent and supervised visits should be made as planned. From these visits families of special interest should be selected for study. Emphasis should be placed on the selection, upon the opportunity presented for case study and construction work.

The following of a case from prenatal to postpartum and through postnatal care, affords a good opportunity for experience and has in the past contributed to the success of the work. But since the requirement as a minimum number of these visits is so reasonable, it ought to be possible to select a prenatal in which a special advantage is offered to the student and her plan of activity should not be interrupted, unless the case seems to offer some special interest. Prenatals early in pregnancy give excellent opportunity for health teaching and should be provided. A certain number late in pregnancy should be observed and visited. Confinements and operations should be arranged for each student for observation.

It is important that the student should have opportunity to use a record system and to realise the extent to which it may promote the work.

At the end of a period of practical experience, the student may then be ready to discuss her cases on conference with staff nurse and supervisor. Every opportunity should be given the student to be present when a case known to her may be discussed in short conference with other agencies.

New cases opened should be observed early; independent work of this type gives the student the chance to discover her problems and work out the method of meeting them while the opportunity for consultation is possible. Every opportunity for the student to show initiative should be allowed, at the same time the student should have the benefit of experience in discussion of work and special emphasis should be placed on dangers arising in the treatment of a case. The supervisor may be most helpful to the student when visits are made with her

in the field and should choose those cases where the advantage of an educational visit is offered.

It is important that the staff nurse or supervisor catch the vision of the student whose ideas may differ from her own. There is no desire to curb the spirit of the student whose originality may be purposeful. To the weak student encouragement may be necessary for development.

In administration the plan should include:

1. A sympathetic understanding of the student and staff nurse.
2. The importance of preserving initiative.
3. The value of concentration in co-operative effort.

III

Plans for Initiation and Subsequent Experience throughout Entire Period from the Standpoint of the Staff Nurse

By KATHLEEN McNAMARA,
Victorian Order of Nurses, Toronto, Ont.

Before meeting the student whom she is to introduce to the field, the staff nurse attends conferences relating to the purpose and content of student field work in general and to particular points of routine. She receives written instructions in the form of a schedule as a guide in carrying out the various types of visits. She has information regarding the previous academic and professional education and experience of the student with whom she is to work. Her plan as instructed (the writer speaks in relation to field work with the Victorian Order of Nurses) gives an early introduction to all types of visits and following the observation period the student participating in independent experience and supervision by the supervisor and staff nurse.

Since the staff nurse has been furnished by the supervisor with this written guide as to the types of visits to be made each day; the approximate time when supervised and independent visits should be made, the staff nurse's plans and responsibilities in the initiation and subsequent experience of her student would include:

1. Daily reference to this guide and plans to carry out the suggestions contained therein, realising her own definite responsibility for the progress and education of her student.

2. Careful introduction of the student into each home. So much depends on giving her a happy welcome or mere tolerance, which would prevent giving the student a situation in which she might teach and leaving a poor contact for repeated visits to that home.

3. Participation of the student in the Order's contacts with co-operating agencies.

4. Discussion of and participation in patient's records. Here one might well take heed of her own care in recording, for the student has so lately studied in theory the value of records. She must observe and participate in careful recording from the beginning of her practice work if one expects continued care in this regard throughout subsequent experience.

5. Frequent reference to her own practice sheet (the student's record of field work for the university) to be sure that all types of visit and supervisions are being included and not left over until perhaps hurried visits would be made just at the conclusion of the field work period.

6. An open mindedness in discussing cases in her district to which the student has been assigned, or has met with the staff nurse —allowing her a feeling of reliance on her own initiative and work. One has visions of one's own student days when although warned in classes that results of work moved slowly, yet how definite were one's own plans for the rapid practical application of theoretical instruction.

The student must feel that the staff nurse is interested in her. Being an infant in public health experience she will depend a great deal on the staff nurse, who is perhaps her first teacher in the practice of the special work she has chosen and the application of her as yet untried theories to those homes. As it is well known individuals must be studied; environment, social handicaps, poverty and all the other things met in daily contacts and teaching modified in relation to these obstacles. Very often one's whole plan for a given visit must be changed until a later and more favourable time in order to meet the immediate need. The staff nurse will serve her purpose in her responsibilities for her student through the careful application of her own experience in health teaching and the carrying out of the routine procedure of her organisation in the development of these various cases.

The plans of a staff nurse for the initiation and subsequent experience of the graduate student throughout the entire period of field work have a very important bearing on the continued experience in practice of this new public health nurse.

IV

Plans for Initiation and Subsequent Experience in School Health Work from the Standpoint of the Staff Nurse

By ELIZABETH PRICE,
Department of Public Health,
Toronto, Ont.

1. The staff nurse will be careful to stress the responsibility of the principal in all school matters.

2. *First Morning*: (1) Observation of morning routine: (a) Setting up Health Service Room; (b) Readmissions with explanations; (c) Exclusions—and forms; (d) Transfers in ———; (e) Dental appointments; (f) Conference with principal, teachers pupils and parents; (g) Filing of work slips; (h) Making work slips or return reports for follow-up visits to homes—visits probably made later in the day with the student observing; (i) Classroom inspection—the student observing. There may or may not be a classroom talk.

Second Morning: (1) The student shares the morning routine; (2) Classroom inspection: two parallel lines of children—one to the nurse, one to the student—close enough for conference. A talk by the nurse followed by a conference with the teacher regarding pupils, with the student observing.

Third Morning: Same—with explanation of records. The nurse supervises the student's part of the work.

Fourth Morning: Classroom inspection done by the student with the nurse supervising; a health talk included. (Most students prefer small children who behave better with visitors. It would seem a good practice to use junior classes. The nurse supervises again in the second week. When there are two or more schools the student might be allowed to carry the smaller one, with the district superintendent supervising.)

3. The records should be fairly well covered by now since explanations were given daily as occasion arose on preceding days.

4. The preparation for complete physical examinations should be made with the student assisting. She should be allowed to carry on alone, from preparation to completion twice during the field work period.

5. Practice in arranging for psychiatric examination with taking of social history.

6. Practice in arranging for special classes, e.g., sight saving, forest school, open air, etc.

7. The student should be allowed (where nurse has one school only) to carry on one day alone in the second week. Problems may arise which can be explained when the nurse returns. Later the student may have this

practice as often as suits the individual case.

8. The school nurse should make clear Toronto's system for procuring glasses, orthopedic appliances, milk, clothing, etc., for school children; i.e., through the district nurse. She should give such a picture of the school work that the student, when she takes charge of a new school, will be able to modify the procedure to suit a given situation.

V

Plans for the Initiation and Subsequent Experience in the Child Health Centre from the Standpoint of the Staff Nurse

By GERTRUDE HUNTER,
Department of Public Health,
Toronto, Ont.

There are several plans which might be used for the initiation and experience of student nurses in child health centres, but the following seems to the writer the most feasible. As each student is usually with a Department of Public Health nurse five weeks, her time be apportioned in this way:

First Week: Devoted to weighing and general observation, which should enable her to obtain:

(1) A general idea of the child health centre and the way it is set up; also of the work and duties of the child health centre nurses.
(2) Type, appearance and condition of the children attending.
(3) Attitude of the mothers.

Second Week: Spent in taking on new histories, which would entail:

(1) Interviewing the mothers and writing information on histories.
(2) Filling in weight cards.
(3) Writing return reports.
(4) Filling in letters to family physicians for the child health centre physician to sign.

Third Week: Devoted to assisting the physician:

(1) In a general way.
(2) Writing his orders, together with any helpful information on return reports for the district nurse.
(3) Interpreting his orders to the mothers and instructing them regarding preparation of feedings.
(4) Giving reference cards to hospital clinics.
(5) Arranging for extra nourishment.
(6) Referring to social agencies.

Fourth Week: Spent in conferences with mothers and in health teaching with regard to:

(1) Regular breast feeding.
(2) Manual expression.
(3) Diet.
(4) Immunisation, etc.

Fifth Week: Devoted to getting a general idea of the records which might prove particularly helpful if a student nurse were planning to work alone in a rural community.

It would seem advisable for the Department of Public Health nurse to review with the student nurse the teaching and experience she has had in the child health centre. This might be done at the completion of each child health centre or in the district office in conference with the superintendent.

VI

Plans for the Initiation and Subsequent Experience in Home Visiting re Communicable Diseases from the Standpoint of the Staff Nurse

By IRENE WEIRS,
Department of Public Health,
Toronto, Ont.

I. *Conference with Student*: Before starting into the home to visit there should be a general discussion with the student as to procedures and relationships, e.g., quarantine regulations pertaining to communicable disease in the district, the responsi-

bility of the public health nurse, emphasizing the fact that one of the first reasons for the nurses being in the district is the prevention and control of communicable disease.

Prevention—explaining the use of existing clinics, means of reference to these and a discussion of existing cases upon which the nurses are working in the district.

Control—explaining the objective in the home visit to a suspicious and a diagnosed case.

A general discussion is important; it helps the student to get the public health nurse's viewpoint and helps the staff nurse to get the student's viewpoint; it creates more intelligent interest in the work to be accomplished in the home.

II. *Observation Visits*: When possible each type of visit should be observed by the student: exclusions from school, emergency calls, discharges from and admissions to hospitals, and the following of contacts. She should observe co-operation with the family physician, the district medical officer and the Division of Quarantine. Plans should be made to demonstrate each step whenever possible, e.g., telephoning, discussion with the district medical officer or district superintendent. The student should observe a diagnosed case cared for by the public health nurse in the home and should realise the nurse's responsibility for teaching a reliable member of the household the care of the patient, and ways of preventing others from contracting the disease. Although the student knows how to nurse communicable disease, it must be realised there is much to learn about care in different homes, inadequate equipment in the homes, and in many cases the poor mentality of the one who is to care for the patients.

Perhaps communicable diseases are not at their height at the time of the year visits are made by the university students, and if it is not possible to see work with her own nurse, the opportunity should be given to go with those nurses who have active cases as different districts offer varied types of experiences.

III. *Experience*: The subsequent experience of the student, following her initiation, should be as varied and full as is possible. She should be allowed to carry the full detail of the work with supervision. The student might carry some cases of tuberculosis (not all would be advisable). It would be ideal if she could carry an active case waiting admission to sanatorium, an active case cared for in the home, and the supervision of contacts.

The field of communicable disease does not always present experience as desired, but not many visits in the home are without an opportunity to teach prevention or control of the common cold.

The following varied points should be covered during the field work period: bag equipment and its use; technique of taking a temperature and caring for the thermometer; the relation of the need for teaching of general health rules in the home to the control of communicable disease: repeated and persistent urging of immunisation against diphtheria and smallpox; the need for persistent effort in dealing with skin conditions. The dress of the public health nurse at all times is also a point in the teaching.

Ideals: The university student comes to the field with an ideal of the part the public health nurse can play in control of communicable disease. In the difficulties met in making adjustment in the home due to poor equipment, etc., it is well to keep ideals constantly in mind, that the situation may be handled as well as is possible.

VII

Plans for the Initiation and Subsequent Experience in Home Visiting regarding Health Supervision from the Standpoint of a Staff Nurse

By GERTRUDE REID,

Public Health Nurse, New Toronto, Ont.

Criteria adopted for students in field work in a large centre cannot always be fully carried out in a smaller community, where there is only one nurse to plan and carry out every phase of the work. There are many demands on her time that are not made upon the staff nurse in a city. Moreover, it is not always possible to find suitable families to give the student supervised experience in home visiting. The people are so accustomed to having one nurse, that it would seem advisable for the student to merely observe in these cases and then go back alone and make her own contacts with the family. Such families must be selected especially for this, as some people are so strongly opposed to all public health work and are inclined to consider the appearance of any new person as undue interference. This might also apply were the student to make three visits to one home in so short a time, as it is seldom a nurse, working alone, visits that frequently. It would be apt to give a wrong impression and wrong impressions, like diseases, are very communicable in a small town.

It may be possible in some rural communities to fully meet the demands of the criteria but in others, the student's time is fairly well filled if she observes and takes part in all the public health nursing activities, that is, if the staff nurse presents her whole programme to the student.

VIII

Modification in the Small Health Centre or Rural Community from the Standpoint of the Supervisor

By ELEANOR SEELEY,

Supervisor, Public Health Nurses, Department of Health, Kitchener, Ont.

Without in any way seeking to modify the adopted schedule for students, the writer finds it becomes modified or curtailed somewhat all round for the following reasons:

1. A highly intensive programme is covered in one month.

2. The greater part of, if not all the first week, must be spent in observation.

3. The students, after a year's academic work, are fagged and appear to be driving themselves. The trying spring weather aggravates this.

4. The demands and exigencies of the staff nurse's own work very often throw the general schedule out. Special activities and emergencies coming up — such as vaccinations which are done about this time, the pre-school examinations in June, etc. —all tend to interrupt a general programme.

5. The schools at this season are working at high pressure, and the staff nurse's inclination is to disturb classes as little as possible.

6. The students work more slowly than experienced nurses, and all their visits, interviews, inspections, etc., are prolonged, taking extra time.

7. Again, owing to the weather, many calls are made uselessly as housewives are often out or engaged in spring cleaning. If a visit is made the circumstances are not always propitious.

8. The work and visits on mental cases have been done indifferently well, because the writer did not know just what the student was expected to have in this line.

IX

Modification in the Small Health Centre or Rural Community from the Standpoint of the Local Public Health Nurse

By GEORGINA CLARK,
Public Health Nurse, Paris, Ont.

Although the writer has had the pleasure of having only one student, the Medical Officer of Health, the Board of Health, all the private physicians of the town, the principal of the schools and the teachers feel that it is quite an honour to have a student visit. The student, with the public health nurse, is made most welcome and a keen interest taken in her so that she may receive the required experience.

The school work may be carried on practically the same as in the city schools. Last year the teachers rather resented the time taken for short health talks but this year they are most enthusiastic, having seen some results.

Difficulties do arise, however, in some of the technicalities of home visits:

(1) The type of visit: Last year there were no communicable diseases in town, consequently that type of visit could not be included in the programme.

(2) The mental hygiene visits were quite negligible as this type was not thoroughly understood and the work being so recently organised no outstanding cases had arisen.

(3) One cannot dissociate social work and public health nursing work when one is the only professional worker in the field, since everyone looks to the public health nurse for advice and help whether of a social nature or a public health one. Unfortunately a large percentage of these families resent the presence of a stranger, and as most of the prenatal visits made are included in this category, it makes it very difficult to give the student much experience in prenatal work.

(4) Visits made by the student alone are difficult. Possibly after the community becomes more accustomed to visitors these will be assigned more readily. As there has been a certain resentment toward the public health nurse visiting in homes it would seem impossible to risk allowing the student to visit alone in case future visiting were denied. If a student could have as much experience as possible in home visiting and some supervision of these visits, this problem would be greatly helped.

At the Child Welfare Conference there is no doctor in attendance. The student is able to put into practice all of her teaching as the majority of mothers are most interested in the welfare of their baby and most anxious to hear about anything that will be helpful. However, in conducting a conference alone the same problems arise as in home visiting alone. It does seem inadvisable to allow this at present.

The writer's opinion is that the Public Health Nursing Course is quite incomplete without some field work with the Provincial Department of Health.

Department of Private Duty Nursing

National Convener of Publication Committee, Private Duty Section,
Miss CLARA BROWN, 23 Kendal Ave., Toronto, Ont.

Are There Too Many Nurses?

By JEAN DAVIDSON, Paris, Ont.

Nurses! nurses! everywhere, and many of them have the same refrain: "I haven't worked for many weeks," and more often, months.

In reading an article, written by Hazel Rawson Codes, much interesting information is given regarding the oversupply of nurses.

The private nursing field is the one which suffers most from overcrowding. True, many fine nurses enter the private duty field and stay in it because they love it, but often the private duty nurse feels discontented, ill adjusted and under-paid. This may be, because she has not had the proper education and technical training for any special branch in the profession.

There is a comparative lack of highly trained nurses for obstetrics, pediatrics and nervous diseases and not enough skilled in diet disease and contagious work.

Better positions are seeking applicants but while there is an abundance of less highly trained nurses, the trouble lies in the lack of educational requirements and facilities. There is a definite effort in the nursing profession to make a complete high school course a minimum requirement.

Dr. G. M. Weir, in the Report of the Survey of Nursing Education in Canada, has submitted some interesting conclusions on work and pay: The private duty nurse averaged 29.9 weeks' work a year, 14.3 weeks' idleness, ill 4.5 weeks and vacation 3.3 weeks; her median annual gross income was $1,022.00. The public health nurse averaged 47.1 weeks' actual nursing duty, 4 weeks' vacation and .9 week's illness; her median annual gross income was $1,575.00. The institutional nurse averaged 46.3 weeks on actual duty, 4.2 weeks' vacation, .8 week's illness and .7 week's unemployment. Her median annual gross income was $1,385.00.

The appeal of the nursing profession is never fundamentally money. It is that vital human quality which is always present in work on such intimate terms with human beings. A good nurse must be strong, deft, poised, tactful, patient, controlled, serene, not dull but sensitive in the best meaning of the word.

Also, she must be animated by intelligence as well as great human understanding. She must be neat, thorough, faithful and sense emergencies and possess the courage to act in them on her own initiative.

Nursing is gradually dovetailing with efforts to improve the health of the people. The aim of any nurse, institutional, public health or private duty, is to leave her patient knowing more about health than he did before he became ill.

There has been and is a great deal of dissatisfaction among private duty nurses, due to the uneven employment and a corresponding irritation in the public mind, of the costliness and sometimes the inadequacy of nursing service. Definite efforts are being made to raise the educational requirement and standardise training; also, plans for organisation of registries in touch with the community so that nurses will be supervised for better service.

From the standpoint of both nurses and public, there is merit in the hourly nursing plan whereby registries charge by the hour for a nurse's services but pay her a flat rate to assure her a dependable living wage.

News Notes

ALBERTA

CALGARY: The Alumnae Society of the Holy Cross Hospital in Calgary came into existence in May, 1931. The Holy Cross Hospital belongs to the Sisters of Charity, or, as they are sometimes called, The Grey Nuns of Montreal. These Sisters have training schools in Canada and in the United States, as well as orphanages, schools and homes for the aged. There are over a hundred graduates of the Calgary School scattered all over the world, even in the far North, where some of the Nuns who are also registered nurses are pioneers in remote and inaccessible places. It was through the efforts of Sister St. Jean de l'Eucharistie, who was the Superior of the Holy Cross Hospital for nine years, and those of Mrs. de Satge, who has been for many years in charge of the Records and is now Instructor of Nurses, that all these nurses were communicated with and an Alumnae Society organised. The inauguration of this society was marked by a reception and tea in the reception room at the Nurses Home, where the guests, over a hundred graduate and student nurses as well as their friends, were received by the Sisters and the officers of the Society. The aims of the Alumnae are: (1) To keep in touch with all graduates of the Holy Cross Hospital, Calgary; (2) To visit the sick nurses and provide them with flowers; (3) To provide indigent patients or their babies with clothing. There are fifty-five paid-up members at present, and the officers are: President, Mrs. L. de Satge; Vice-President, Miss A. Willison; Corresponding Secretary, Miss P. N. Gilbert; Recording Secretary, Miss E. Thom; Treasurer, Miss S. Craig; Honorary Members, Rev. Sister St. Jean de l'Eucharistie, Miss M. E. Brown.

LETHBRIDGE, ALTA.: The regular meeting of the Lethbridge Graduate Nurses' Association was held at St. Michael's General Hospital on January 11, 1932. The meeting was preceded by a delicious banquet served by the Sisters of St. Michael's. Approximately forty nurses were present. The speaker of the evening was Mr. A. E. Russell of the Metropolitan Life Insurance Company.

At the February meeting an election of officers was held. Officers for 1932 are as follows: President, Miss L. Parry; Vice-President, Miss M. Slater; Secretary, Miss B. Ford; Treasurer, Miss J. MacKenzie; Registrar, Miss A. Tilley; Conveners of Committees: Social, Miss McGowan; Programme, Miss B. Clark; Membership, Miss L. Watson; Sick Visiting, Mrs. P. M. Sauder; Local Council, Mrs. R. Wilson; Conveners of Sections, Private Duty, Miss L. Larson; Nursing Education, Miss H. Levenick. Regular meetings held on the second Monday of each month.

The March meeting was held at the home of Miss L. Watson, twenty nurses being present. Arrangements were made for the annual dinner and bridge. Following the business meeting Dr. R. W. Lynn gave a very interesting talk on Birth Control. Miss Heather Jardine was appointed as the Lethbridge delegate to the A.A.R.N. Convention at Edmonton on March 22nd and 23rd.

On April 11th the Association held its annual dinner. Approximately forty nurses from Lethbridge and district were present. The catering was undertaken by the Women's Auxiliary of a local church. Following the dinner, Mr. T. Burnett, with his kaleidoscope. took the guests on a world tour, including the Holy Land, Egypt, the Orient, India and Honolulu.

On April 26th the Association entertained the Graduating Class of Galt Hospital at a delightful Spring Tea given at the home of Mrs. P. M. Sauder.

The regular monthly meeting in May was held at the home of Mrs. R. W. Lynn. The financial report showed a credit balance of $73.76. The Registrar's report gave the names of three additional members. Miss H. Jardine, delegate to the A.A.R.N. Convention, gave a splendid report of the Provincial Meeting. The members found it most enlightening and many discussions followed. The next meeting was held at the Galt Hospital on June 13th.

GALT HOSPITAL, LETHBRIDGE: The graduation exercises were held at the Wesley Church, April 28th. Eight nurses received their medals and diplomas. Following the ceremony, the graduating class and their friends were entertained at a dance in the Masonic Hall, given by the Hospital Board.

MEDICINE HAT: The Graduation Exercises of the Medicine Hat Training School for Nurses were held at Fifth Avenue Church on June 2nd. The church was filled to capacity, and amid a profusion of beautiful flowers the graduates received their diplomas, which were presented by Miss Mary N. Murray, acting superintendent. Mayor Bullivant presented the special prizes ,which were awarded to: Miss Ellen Ostlund, general proficiency; Miss Kathleen Bell, surgery; Miss Beatrice Harvey, obstetrics; Miss Violetta Neal, practical work. Mr. G. M. Blackstock addressed the graduating class and Dr. B. C. Armstrong administered the Nightingale Pledge. A musical programme was given by local artists.

The Medicine Hat Graduate Nurses Association was represented at the Biennial Convention in Saint John by Mrs. Mary Tobin.

The Association has suffered the loss of one of its most outstanding members in the death of Miss Edna Mabel Auger on May 2, 1932. The late Miss Auger was born in Chatham, Ont., and when seven years of age the family moved to Maple Creek, where she received her early schooling, going east to Ontario to

take her high school course. She returned to Medicine Hat in 1903 and, entering training in the General Hospital, graduated in 1906. then becoming operating room nurse on the staff of her alma mater. In 1910 she went to New York for post-graduate work. In that city she worked under Dr. Erdman at Dr. Bull's hospital until 1913, when she returned to Medicine Hat as assistant superintendent.

Commencing overseas service in 1915, Miss Auger served with the Canadian Army Medical Corps Nursing Service until she returned home late in the fall of 1919. A year later she organised a hospital at Grande Prairie, but came back in 1921 to take the position of lady superintendent of the Medicine Hat General Hospital, which position she held at the time of her death.

While overseas she won a high reputation of efficiency in her work, and for bravery in the face of danger she was awarded the Royal Red Cross medal. At home in more peaceful surroundings she enhanced that reputation by her efficient administration and devotion to duty while in charge of the hospital here.

The death of Miss Auger marks the passing of one who visualised her life work, prepared herself for it, following in the noble footsteps of Florence Nightingale, ever effusing the radiance and nobility of a life for others.

BRITISH COLUMBIA

Results of Examination for Registered Nurse's Certificate

An examination for Title and Certificate of Registered Nurse was held recently throughout the province of British Columbia with the following results:

154 wrote the examination.
142 passed.
4 passed with supplementals to write.

Standing order of merit:

First Class—80% and over:

Misses J. H. Collett, Royal Jubilee Hospital, Victoria; M. G. Prescott, Vancouver General Hospital; E. F. Crampton, St. Joseph's Hospital, Victoria; M. J. Birdick, St. Joseph's Hospital, Victoria; M. A. Clarke, Royal Jubilee Hospital, Victoria; Mrs. N. M. Dickinson, Royal Inland Hospital, Kamloops; A. M. Milnes, Vancouver General Hospital, Vancouver.

Second Class—65% to 80%:

Misses K. M. McDonald, R. W. MacGillivray, Sister Ignatia, (A. M. Field and H. B. Keeler—equal), H. G. Barron, D. E. Cann, (G. B. Harvey and C. C. Ford—equal), (I. J. Clark, M. Ballderston and M. L. Dobbin—equal), M. Jaques, M. L. Mott, M. T. Hodgson, R. F. McKernan, (E. C. Miller and L. W. D. Haines—equal), (M. M. Wilson and M. I. Maddaford—equal), B. V. G. Ross, M. Campbell, (M. Leman, M. MacIvor and F. Willan—equal), M. E. Smith, E. Taylor, (A. E. Robertson, E. D. Greenlees—equal), F. I. Goward, D. M. Hall, M. M. Fletcher, L. M. Blomberg, M. Laity, (E. E. Braund and W. R. Travis—equal), (M. C. Otterbine, H. E. Stephen and E. E. Rossiter—equal), (H. M. Bell and I. V. Hewer—equal), (I. Clare and F. Gillies—equal), (M. E. Smart, Sister M. Audrey, E. N. Wadelin and O. M. Gray—equal), M. D. Burtch, (K. E. Green and E. Pease—equal), L. M. Hughes, (H. McL. Mutrie, M. F. Clements and T. I. Kearns—equal), K. Hessey, (K. Moore and K. M. Stowe—equal), (E. C. Bragg and G. S. Christie—equal), (E. S. Dempsey and M. Woollett—equal), Mrs. G. M. Beech, (M. A. McIntyre and M. E. J. Spooner—equal), (J. M. Blake, J. McL. Nicholson and E. O. Mitchell—equal), E. F. Cunningham, E. K. Birley, (P. M. Bond, E. Collins, V. M. Neil, L. Lieman and B. O. Orr—equal), (M. A. Amos and M. C. Naylor—equal), (M. B. Cummings, M. R. Earle, L. T. Fagan and M. J. Field—equal), (R. J. Younge, E. L. Johnson—equal), (M. Gracey and D. M. Clarke—equal), M. L. Armand, (F. E. H. Whitaker, T. LaR. Baker—equal), (M. A. Burnes, E. Reid and P. E. Rockwell—equal), O. Foss, (E. M. Moody and Sister J. de la Passion—equal), (P. Riley and D. S. Grant—equal), (M. A. Ennis, M. E. Gibbons and M. E. Rasmussen—equal).

Passed—60% to 65%:

Misses (K. V. Johnston, A. G. C. Hallstrom, Mrs. O. Purvis, E. E. Short and C. Reid—equal), (G. M. Smith and J. T. Stelmack—equal), (Chelta Reid, G. M. Higgs and E. A. Postill—equal), (M. J. DuMont, M. G. Buckan, D. E. Lovering and M. I. Hoggan—equal), (H. M. Flumerfelt and A. M. Gee—equal), Sister M. Faustina, (I. G. Facey, A. J. Lathrop and E. E. MacKenzie—equal), I. M. Matheson, M. M. Foster, D. L. Lee, (S. I. LeQuiea and E. V. Stenner—equal), (E. D. Doe, L. C. Wilson and L. E. Tripp—equal), (P. O'Sullivan and J. E. Fontana—equal), B. D. W. McGillivray, J. L. J. Bourke, S. I. Maki, (L. Crandlemire and M. E. Falding—equal), V. M. Darney.

Passed in supplemental:

Miss E. V. Johnston.

Passed with supplementals to write:

Misses L. I. Buckmaster, H. K. Beckett, (N. E. Foster and I. M. Morgan—equal).

MANITOBA

BRANDON: The graduation exercises of the General Hospital were held on May 24th in St. Paul's United Church, when twenty-two nurses received their diplomas and pins from Robert Darrach, chairman of the Board, and Miss C. McLeod, Superintendent of the Training School. Dr. J. S. Matheson presented the medals—the Gold Medal to Miss Edith Duncan, the Silver Medal to Miss Ada Stanley, Bronze Medal to Miss Jean Meyers, Prize for General Proficiency to Miss Elizabeth Flett, and a prize for Dietetics to Lucy Lacey. In the intermediate year, Dr.

Bigelow's prize for surgery was won by Betty Birks, who also received the prize for highest standing in her year. Dr. Peter's prize was awarded to Gladys Slimons, and Dr. Sharpe's prize for paediatrics to Agnes McMillan. In the junior year Marjorie Jackson received the prize for General Proficiency awarded by Dr. Purdy Griswald, and Miss Brigham won Dr. Elliott's prize for highest standing in first year. Musical numbers were contributed by Miss Ruth Morgan and Dr. E. S. Bolton. A reception was held in the Nurses' Home, where Miss McLeod, Robert Darrach, and members of the graduating class received their friends.

NEW BRUNSWICK

The Saint John Chapter of the Registered Nurses Association held its closing meeting of the season in the Nurses Home of the Saint John General Hospital on May 16th. Miss E. J. Mitchell, the president, was in the chair. When the coming convention was spoken of, it was estimated there would be between two hundred and fifty to three hundred nurses assembled at the Biennial Meeting of the Canadian Nurses Association. Outstanding leaders in the profession will take part in the programme.

Saint John General Hospital, Saint John: Mrs. G. L. Dunlop was elected president of the Alumnae Association at the meeting held in the Nurses Home on May 9th. Others elected were as follows: First Vice-President, Miss Ethel Henderson; Second Vice-President, Mrs. F. M. McKelvey; Treasurer, Miss K. Holt; Secretary, Miss Jane Thorne; additional members, Mrs. J. H. Vaughan, Mrs. H. H. McLellan and Mrs. A. C. Clinch. Gratifying reports of the work of last year were presented.

ONTARIO

Paid-up subscriptions to "The Canadian Nurse" for Ontario in June, 1932, were 973, forty-one more than in May, 1932.

Appointments

Miss Grace Chapman has been transferred to the Mountain Hospital, Hamilton. Miss Mary Langford has been transferred from the Mountain Hospital to the General Hospital, Hamilton.

District 1

Victoria Hospital, London: The annual picnic of the Alumnae Association was held recently at Springbrook Park. Ninety-eight members with their friends and children were given a most enjoyable outing. A dainty lunch was served by the refreshment committee, and in the evening a novel programme of games and races was introduced. Miss M. Jones, the president, made an interesting announcement regarding a golf tournament to be held at the Fairmont Golf Course.

District 2

General Hospital, Guelph: It is very much regretted that Miss Bliss has resigned as superintendent of the General Hospital and left on May 14th to go to her home at Perth, Ont. The Alumnae Association entertained at afternoon tea and presented Miss Bliss with a beautiful silver tray. Presentations were also made by the staff members of the Hospital, student nurses and Medical Association.

Miss Hardey left June 1st for Toronto Western Hospital, where she will take a three months' course in operating room technique.

Miss Dennis and Miss Fennel recently received their diplomas in Public Health Administration at the graduating exercises of Western University, London.

Miss Watson, who has been very ill, has gone to her home in Fergus, Ont., much improved.

Homewood Sanatorium, Guelph: The graduating exercises of the 1932 Class were held on May 31, 1932, at the Sanatorium.

St. Joseph's Hospital, Guelph: The graduating class of 1932 were entertained at dinner by the Alumnae Association on May 31st at the Edgehill Tea Room. The graduating exercises were held on June 2nd at the Collegiate Auditorium.

Kitchener-Waterloo Hospital, Kitchener: National Hospital Day, May 12th, was observed at the Kitchener-Waterloo Hospital, when the building was thrown open for inspection.

The Alumnae Association entertained the 1932 graduates at a banquet on May 12th. The graduation exercises of the Hospital were held on May 19th at the Collegiate Auditorium.

On May 26th the staff and pupil nurses of the Hospital and graduate nurse friends of Miss Mary Ward, assistant superintendent, showered her with gifts in view of her approaching marriage.

Norfolk County Hospital, Simcoe: Miss H. Booth has been vacationing for the past week in Clinton, Ont. Miss P. Pringle has spent a week at her home in Owen Sound.

General Hospital, Brantford: The graduating exercises of the 1932 Class were held on June 3rd at the Brantford Collegiate Institute, when twenty-five young women received their pins and diplomas. Scholarships were won by: Misses Clara Biffin, Jean Zurbrigg, Lena L. VanEvery; Intermediate scholarship, Miss Jean Baird; and Junior Year prize, Mrs. Mildred Gehman. Mr. Norman Somerville, K.C., addressed the graduates. A reception was held immediately following the exercises, when the guests were received by Miss E. M. McKee and Miss Jessie M. Wilson. In the evening Miss McKee entertained at a dance in honour of the graduates at the Brantford Golf and Country Club.

The graduating class of 1932 were guests of honour at the alumnae reunion, which took the form of a dinner dance at the Brantford Golf and Country Club.

District 4

General Hospital, Hamilton: Members of the Alumnae Association entertained at tea in honour of the 1932 graduating class. The guests were received by Miss E. C. Rayside, Superintendent of Nurses, Miss

Clark, Superintendent of Nurses of the Mountain Hospital, and Miss Buchanan, president of the Alumnae. Presiding at the tea table were: Mrs. B. McBride, Mrs. R. Hess, Miss May Hipwell, Mrs. J. B. Lannin and Mrs. James Roberts.

District 5

Toronto: A general meeting of District No. 5, R.N.A.O., was held at the Royal York Hotel on May 21, 1932. During the afternoon session reports from various committees were received and abstracts from the Survey of Nursing Education in Canada were discussed by the Public Health and Private Duty sections. A dinner meeting was held in the roof garden, when about 120 members were present. The speakers were Miss Jean E. Browne and Dr. E. M. Best. Miss Browne outlined briefly Dr. Weir's report of the Survey. Dr. Best spoke of the qualifications of the individual that society is looking for today. Professional education was the prevailing spirit of the evening.

Western Hospital, Toronto: On May 10, 1932, in the Nurses Residence, the members of the Alumnae Association were honoured by the presence of Miss Florence Emory, President of the C.N.A. A brilliant address on the history of the C.N.A. and the importance of membership in that organisation was given by Miss Emory. The meeting closed with a social hour.

On April 27th, 1932, the Alumnae Association entertained the graduating class with a banquet given in the roof garden of the Royal York Hotel. Covers were laid for one hundred members with thirty-four of the graduating class. Speeches, toasts and a valedictory contributed brightness to the affair. The toast to the class was proposed by Miss Mary Bird (1927); Miss Kathleen MacMillan (1929) proposed the toast to our alma mater, which was responded to by Miss Ellis, Honorary President. Miss Ludlow (1931) proposed a toast to the absent members, which was responded to by a letter from Miss Frances Wiltsie (1930). The entertainment was concluded by dancing and bridge.

The graduating exercises of the Toronto Western Hospital took place at Convocation Hall of the Toronto University on June 2, 1932. Rev. Canon Cody, D.D., LL.D., gave the invocation and address. Mrs. Alex. Fasken presented the diplomas and pins. A number of prizes and a scholarship were awarded several members of the graduating class. The H. A. Beatty Scholarship, McGill University, Montreal, for one year's post-graduate work in Teaching and Administration was presented to Miss Kathleen MacMillan (1929). A prize of twenty-five dollars from the Alumnae Association was presented to Miss Pearl Shore (1933) for Proficiency in Bed-side Nursing. Following the exercises a reception was held in Hart House.

Miss Ruth Kenney (1920), of Miami, Florida, visited the hospital and class-mates recently.

District 5

Toronto General Hospital, Toronto: Miss Joliffe (1931) has left for Saskatchewan to do district nursing. Miss Doris Williams (1930) has gone to North Dakota, and Miss Eunice Bebres (1931) to Seattle, to do district nursing.

A delightful shower for Miss Frances Hannaford (1923) was given by Miss Meta Gretzner, at which about twenty members of the 1923 class and others were present.

Collingwood: The annual meeting of the Nurses Alumnae of the General and Marine Hospital was held in the Board Room of the Hospital on May 27th. After the business had been fully dispensed with the secretary reported seven regular meetings held during the year, with an average attendance of ten members. A number of social functions were held during the year. Also several new articles added to the room which the Alumnae is furnishing in the Hospital. The Treasurer reported a membership of thirty-three in good standing, with four in arrears. Officers elected for the ensuing year are as follows: Honorary President, Mrs. Price; President, Miss K. Hanley; First Vice-President, Miss L. Ludlow; Second Vice-President, Miss B. McQueen; Secretary, Miss F. Pearen; Treasurer, Mrs. J. McAllister; Social Committee, Mrs. F. Watts, Misses Robinson and Cooper; Telephone Committee, Misses Robinson, Brown and Faulkner.

Oshawa: The graduation exercises of the General Hospital Training School for Nurses were held in the Collegiate Auditorium on June 7th. Ten candidates received their diplomas and medals.

District 6

Ontario Hospital, Whitby: The Alumnae Association honoured the 1932 graduating class with a dinner and dance. This was held on May 16th at the Falcon Inn, Kingston Highway. The speakers of the evening were Miss R. G. Bryon, Honorary Preident of the Association; Miss P. Sharpe, President; Miss E. Porter, representative to The Canadian Nurse. Miss L. Fair, Miss L. Scholtz and Miss M. Coe spoke on behalf of the graduating class. Mrs. Merson, Instructor at the Whitby Institution, spoke briefly on some aspects of nursing life. Everyone spent a very pleasant evening.

District 8

Pembroke: The spring meeting of District No. 8 was held in Pembroke on May 21, 1932, with about one hundred nurses from Ottawa and vicinity present. During the luncheon, held in the school room of Calvin United Church, the speakers were Dr. Sparling, Medical Health Officer of Pembroke; Mr. McCormick, of the Board of Governors of the Cottage Hospital; and Rev. Allen, of Calvin United Church. At the afternoon session Dr. C. M. Purcell gave an interesting address on "Teeth and Health". This was followed by a demonstration of First Aid by a St. John's Ambulance team from Ottawa. The afternoon was brought to a close by a

tour of the hospitals, followed by a delightful tea at Pettawawa, which was sponsored by the nurses of Pembroke. The members of Distict No. 8 feel they owe a debt of gratitude to Miss Hodgins, Superintendent of the Cottage Hospital, and to Sister Mary Bridget of the General Hospital; also to the Board of Governors of both hospitals for making possible a day so filled with pleasurable interest.

LADY STANLEY INSTITUTE, OTTAWA: The annual meeting of the Alumnae Association was held at the home of Mrs. G. O. Skuce on May 13th. The following officers were elected for the coming year: Hon. President, Miss Mary Catton; Hon. Vice-President, Miss Florence Potts; President, Miss Jean Blyth; Vice-President, Miss M. McNeice; Secretary, Mrs. L. Morton; Treasurer, Miss Mary Slinn; Directors, Misses McColl, McQuade, Bedford and Mrs. Elmitt; Press Representatives, Misses E. Allen and A. Ebbs; Flower Convener, Mrs. V. Boles.

QUEBEC

GENERAL HOSPITAL, MONTREAL: The following members of The Montreal General Hospital Alumnae Association were among those who received certificates from McGill School for Graduate Nurses on Convocation Day, May 25, 1932: Miss Kate L. Annesley (1928) received certificate for Teaching in Schools of Nursing; Misses Edna L. Church, Ethel B. Cook (both 1928), and Miss Louise Stedham (1930), all received certificates for Public Health Nursing.

The Alumnae Association arranged an informal reception in the School for Nurses in honour of the graduating class 1932. The guests, who numbered approximately 300, were received by the President, Miss E. Frances Upton, and Miss Mabel K. Holt, Lady Superintendent, and included, besides the class, all those who had assisted with the education of the Class during the past three years. The event was a most enjoyable one, resembling a large family reunionn.

Sixty nurses received their medals and diplomas on June 3, 1932: Misses V. B. Almond, M. E. Bernard, G. E. Blakney, A. G. Brewer, E. E. Campbell, E. M. Coffin, D. L. Cosman, A. F. Coughtry, N. F. Crandell, E. I. Denman, J. P. Dustin, F. S. Evans, I. A. Frizzell, M. E. Fulton, I. F. Gemeroy, G. M. Goobie, M. C. Hamilton, A. J. Harvey, M. K. Henstridge, G. P. Hjertholm, J. E. King, H. P. Lockhart, E. R. Marshall, E. M. Maynes, N. N. Meighen, F. E. Melkman, M. de S. Murphy, I. N. MacIver, F. M. MacKinnon, K. C. McLeod, V. M. MacRae, D. M. McCracken, K. S. Osmond, D. R. Petrie, A. B. Rodger, M. A. Shannon, H. K. Shaw, C. B. Sprigings, E. M. Sykes, M. K. Wilbur, C. H. Wilson, D. E. Wosltenholme; Final Standing 80% and over for theoretical subjects in the, Nursing curriculum: Misses C. L. Anderson,, M. A. Baxter, E. M. Bradford, N. T. Christie, M. G. Copland, E. Donald, E. M. Fisk, C. H. Foster, C. Michaels, Y. Michaud. E. W. Moffat, A. M. Murphy, M. E. McKiel, O. M. Roe, M. E. Small, B. E. Steele, B. C. Underhill, E. H. Watson.

Prizes presented by the Board of Management of the Hospital for General Proficiency were awarded to Miss F. M. MacKinnon and Miss B. E. Steele, and the Mildred Hope Forbes Scholarships, awarded for the highest aggregate marks during the three years, were received by Misses N. T. Christie and C. L. Anderson.

Miss Norena S. MacKenzie (1926), certificate for Teaching in Schools of Nursing, McGill School for Graduate Nurses (1928), has been awarded a special scholarship from the Mildred Hope Forbes Memorial Fund. Miss MacKenzie expects to leave for England on July 2nd, and will follow a post-graduate course of study and experience which has been arranged by Miss Parsons, Director of Education, College or Nursing, London, England, and will cover a period of several months. Miss MacKenzie, who is a native of London, Ontario, has been a member of the teaching staff of the Montreal General Hospital, since 1928 previous to which she did Red Cross Outpost Duty in Ontario for one year.

Among those who left Montreal to attend the Biennial Meeting of the C.N.A. in Saint John are: Misses Jennie Webster, M. K. Holt, Agnes Jamieson, C. M. Watling, Eleanor Handcock, Beatrice Hadrill, and E. Frances Upton.

EASTERN HOSPITAL, MONTREAL: The programme committee were fortunate in procuring Dr. E. C. Menzies to address the Alumnae at the regular meeting in May, which was held in the Nurses Home. Dr. Menzies spoke on Nervous Diseases in a most interesting manner. The usual social half-hour was spent afterwards. Mrs. H. F. McLean (Irene Robertson, 1916), of Merrickville, Ont., left early in April to spend some time travelling in Europe. Miss Lillian Brand, accompanied by friends, sailed from Montreal for France on May 7th. Miss Jean Whimbey has returned to Montreal from Bermuda, where she spent the winter months.

HOMOEOPATHIC HOSPITAL, MONTREAL: Mrs. H. Pollock has returned to Montreal from Bermuda, where she spent a short vacation. Miss M. E. Anderson (1931) has been appointed to the night staff in charge of the Case Room. Sympathy is extended to Miss D. W. Miller in the loss of her father; also to Mrs. C. Ciceri (Ruth Mowry, 1918) and Mrs. T. Costigan (Esther Mowry, 1930) in the loss of their sister Mildred, (1926).

THE CHILDREN'S MEMORIAL HOSPITAL, MONTREAL: The annual dinner given to the graduating class by the Alumnae Association was held at the Queens Hotel on May 9th. Miss Marion Lindeburgh of McGill University gave a most interesting talk. Miss I. Young, soloist, rendered two delightful selections.

The graduating exercises were held in the hospital on May 10th. Dr. Goldbloom gave

an inspiring address to the class. Mrs. Gordon MacDougall presented the pins and diplomas. Miss A. S. Kinder received at a most enjoyable dance the same evening in honour of the graduates.

Miss A S. Kinder and Miss E. Hillyard attended the Biennial Meeting of the Canadian Nurses Association held in Saint John, N.B.

Members of the Alumnae wish to join in offering congratulations to Miss M. Flander (1928), who has just completed a most successful year at the school for Graduate Nurses, McGill University. Miss Flander graduated with honours and was presented with the Lieutenant-Governor's Silver Medal.

Miss R. Miller (1928) has just completed a successful year at the School for Graduate Nurses, McGill University.

Miss B. Goobie, St. Johns, Newfoundland, is spending the summer in Montreal.

Miss J. Cochrane, of the O.R. staff, is away on vacation.

SASKATCHEWAN

THE CITY HOSPITAL, SASKATOON: The graduation exercises of the School of Nursing were held in Third Avenue United Church on May 12th. Miss E. Paloway received the general proficiency prize; Miss L. M. Thompson the gold medal for the highest standing in the senior division; and Miss J. Williamson the gold medal for the highest standing in the junior division. The S.C.H. Alumnae entertained the 1932 graduating class at a banquet in the Hudson Bay Dining Room on May 15th. Nurses representing many classes were present. Grace was said by Mrs. Miscampbell the first graduate of the school. The toast to the King was given by Mrs. Pendleton; The School, Miss E. Amas, responded to by Miss Watson; The Graduating Class, Mrs. Pulley, responded to by Miss Kettles. About one hundred nurses from the City Hospital attended service in Knox Church on Sunday night; Rev. J. A. MacKenzie gave the baccalaureate address to the graduating class. Over two hundred nurses in uniform attended the Florence Nightingale service in Third Avenue United Church on May 9th. The new wing of the City Hospital was opened on May 12th. The S.C.H. Alumnae has furnished three rest rooms, and the Soldiers' ward has been furnished by the I.O.D.E. chapters.

NATIONAL HOSPITAL DAY AT HOTEL DIEU HOSPITAL

Chatham, N.B.

The Weatherman broke all records on May 12 of this year (1932). Following a week of sunshine, the day dawned warm and balmy, though somewhat cloudy. As the hour of noon approached, the sun broke through the mists, and we knew that the afternoon would be a pleasant one. This was a unique pleasure, when we recall that in former years the weather on this day has been anything but pleasant.

Two o'clock in the afternoon, the hour marked for the opening of hospital doors to the public, saw streams of visitors wending their way up the hill, to see, probably for the tenth time, since the inauguration of this Hospital Publicity Day, the institution which they have learned to recognise as the best friend in time of greatest need. Young and old passed gaily through the halls, visiting the different departments, and meeting perhaps, some familiar faces among the nursing staff, some who had cheered them through the lonely days of illness and suffering, in one or other of these departments.

Hospital Day means a day of teaching as well as of pleasure, and as the many visitors passed along the corridors, they were confronted by signs and signals at every turn, each in its own way pointing out the road to better health. On the third floor, the little ones were greatly interested in two tiny houses, which appealingly invited them. The Health House was built with all the food-stuffs that go to make up the strong and sturdy boy or girl. The Unhealthy House, though presenting attractive colours and tempting sweetmeats, was nevertheless condemned as a menace to the health of growing children.

On the second floor a class of little boys and girls, under the direction of two graduate nurses, demonstrated to an eager and admiring audience the first-aid lessons which are being taught in the class-rooms of the present-day schools.

The first floor was alive with a very busy group, for there the ladies of the Hospital Aid served dainty and attractive lunches to the visitors of the hour.

The very dainty and useful contribution to the nursery, on display, by the members of the I.O.D.E. needs no comment, for all visitors to the institution are fully aware of the fact, that the nursery and its tiny occupants are kept always in tip-top shape by these wonderful providers.

The Well-Baby Clinic brought to the hospital a number of little people who were gladly welcomed by the nursing staff, as Hotel Dieu Hospital babies, whose continued good health is a source of much pleasure to those who were the first to welcome them to the sunshine and gladness of old Mother Earth.

But the day with all of nature's brightness and warmth and good cheer would not have been half so attractive and pleasure provoking had it not been for the wonderful music supplied by the members of the Newcastle Band, who were among the first to reach the hospital entrance at 2 p.m. At frequent intervals during the afternoon the breezes carried soft melodies of the orchestra to the most remote parts of the extensive grounds.

One attractive feature of the different departments on this day was the display

of the many rare and beautiful potted plants in full bloom. This was due to the generosity of Mr. R. A. Snowball, who sent these beauties of nature to grace the occasion.

The school children were not left out of hospital celebrations. Miss Sophie McDonald, Reg.N., gave a pleasing and instructive lecture to the pupils of the higher grades, on "Communicable Diseases," showing how even they can help to combat these enemies of the human race. The younger children had their share of hospital instruction by listening to the reading of helpful little stories pointing out the rules of the Health Game.

A special feast had been reserved for all the pupils of the classes through the courtesy of the Marven Biscuit Company, who donated a generous supply of toothsome dainties on the request of the hospital superintendent.

When the gift baskets have been returned Hotel Dieu will welcome another occasion of thanking the public for their continued and generous aid in caring for the suffering.

Six o'clock closed National Hospital Day celebrations, when upwards of four hundred visitors returned to their homes, well satisfied with all the pleasures that the day had offered.

BIRTHS, MARRIAGES AND DEATHS

BIRTHS

CRAWFORD—On April 11, 1932, at Wingham, Ont., to Mr. and Mrs. Harley Crawford (Bernice Brown, Toronto General Hospital, 1930), a daughter.

COO—Recently, at Sudbury, Ont., to Mr. and Mrs. Cecil Coo (Madeline Dudley, Toronto General Hospital, 1923), a son.

HAMBLY—On May 9, 1932, at Montreal, Que., to Mr. and Mrs. Frank T. Hambly (Edith Black, Western Hospital, Montreal, 1925), a son.

HARRIS—On May 6, 1932, at Ottawa, Ont., to Mr. and Mrs. Fred Harris (Ruth Duquette, Ottawa Civic Hospital, 1929), a daughter.

HILLIKER—On April 29, 1932, at Toronto, Ont., to Dr. and Mrs. Hilliker (Kathleen Keyes Toronto General Hospital, 1920), a daughter.

IRVING—On April 11, 1932, at West Shefford, Que., to Mr. and Mrs. Lawrence Irving (Alida Thompson, 1925), a daughter, Margaret Patricia.

JOHNSTON—On April 25, 1932, at Ottawa, Ont., to Mr. and Mrs. John Dewey Johnston (Eva L. Thomson, Winnipeg General Hospital, 1923), a son, John Donald.

McCONNELL—On May 26, 1932, at Toronto, Ont., to Mr. and Mrs. McConnell (Clara Wheatley, Toronto General Hospital, 1919), twin daughters.

McWILLIAMS—On February 26, 1932, to Mr. and Mrs. McWilliams (Freda Conley' Brandon General Hospital, 1926), a son.

PEARSON—Recently, at Brandon, Man., to Mr. and Mrs. Pearson (Christina Junek, Brandon General Hospital, 1930), a daughter.

ROWLEY—On April 20, 1932, at Montreal, Que., to Mr. and Mrs. R. B. Rowley (Frances Armitage, Western Hospital, Montreal, 1921), a son.

UREN—On May 31, 1932, at Toronto, Ont., to Dr. and Mrs. Leslie Uren (Mildred McGuffin, Toronto General Hospital, 1926), a daughter.

WILSON—On April 28, 1932, at Toronto, Ont., to Dr. and Mrs. Roy Wilson (Maud, R. Webb, Toronto General Hospital, 1914), a son.

WILSON—On May 3, 1932, at Ottawa, Ont., to Mr. and Mrs. Ernest Wilson (Audrey Cheney, Ottawa Civic Hospital, 1930), a daughter.

WOODS—On May 19, 1932, at Ottawa, Ont., to Mr. and Mrs. John E. Woods (Luella McEwan, Lady Stanley Institute), a son.

YEIGH—On May 20, 1932, at Toronto, Ont., to Mr. and Mrs. Yeigh (Margaret Pelton, Toronto General Hospital, 1920), a son.

MARRIAGES

GARRETT—WILSON—On April 20, 1932, at Toronto, Ont., Lillian Wilson (Toronto General Hospital, 1928) to Dr. Douglas Rogden Garrett, of Weston, Ont.

HIRD—ARMSTRONG—On May 23, 1932, at Brantford, Ont., Marjorie Ellen Armstrong (Brantford General Hospital, 1931) to Albert E. Hird. Residing in Brantford Township, Ont.

LUCAS—TAYLOR—Recently, at Minnedosa, Man., Helen Taylor (Brandon General Hospital, 1930) to E. J. Lucas.

MYLREA—DENYES—On February 20, 1932, Freda Denyes (Toronto General Hospital, 1920) to James Mylrae, of Toronto, Ont.

TROTTER—BRIGGS — Recently, Norma Briggs (Brandon General Hospital, 1930) to Dr. Harold Trotter. Residing in the Flin Flon, Man.

DEATHS

MOWRY—On May 14, 1932, at Montreal, Que., Mildred Mowry (Homoeopathic Hospital, Montreal, 1926).

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Regular meeting held first Tuesday in each month at 7.30 p.m. at the Nurses Residence.

A.A., BRANTFORD GENERAL HOSPITAL

Hon. President, Miss E. Muriel McKee, Superintendent; President, Miss I. Marshall; Vice-President, Miss A. Hardisty; Secretary, Miss H. D. Muir, Brantford General Hospital; Assistant Secretary, Miss F. Batty; Treasurer, Miss L. Gillespie, 14 Abigail Ave., Brantford; Social Convener, Miss M. Meggitt; Flower Committee, Misses P. Cole and F. Stewart; Gift Committee, Mrs. D. A. Morrison, Miss K. Charnley; "The Canadian Nurse" and Press Representative, Miss E. M. Jones; Representative to Local Council of Women, Miss G. V. Westbrook.

A.A., BROCKVILLE GENERAL HOSPITAL

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A.A., HAMILTON GENERAL HOSPITAL

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Regular Meeting—First Thursday of each month.

A.A., OSHAWA GENERAL HOSPITAL

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A.A., LADY STANLEY INSTITUTE, OTTAWA
(Incorporated 1918)

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Meetings will be held the second Tuesday in each month at 8 p.m. in the Assembly Room, Nurses Residence, Toronto Western Hospital.

A.A., WOMEN'S COLLEGE HOSPITAL, TORONTO

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Meetings at 74 Grenville St. second Monday in each month.

A.A., CONNAUGHT TRAINING SCHOOL FOR NURSES, TORONTO HOSPITAL, WESTON

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Meeting, first Monday each month.

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Regular Meeting—Second Tuesday of January, first Tuesday of April, October and December.

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A.A., ROYAL VICTORIA HOSPITAL, MONTREAL

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